MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

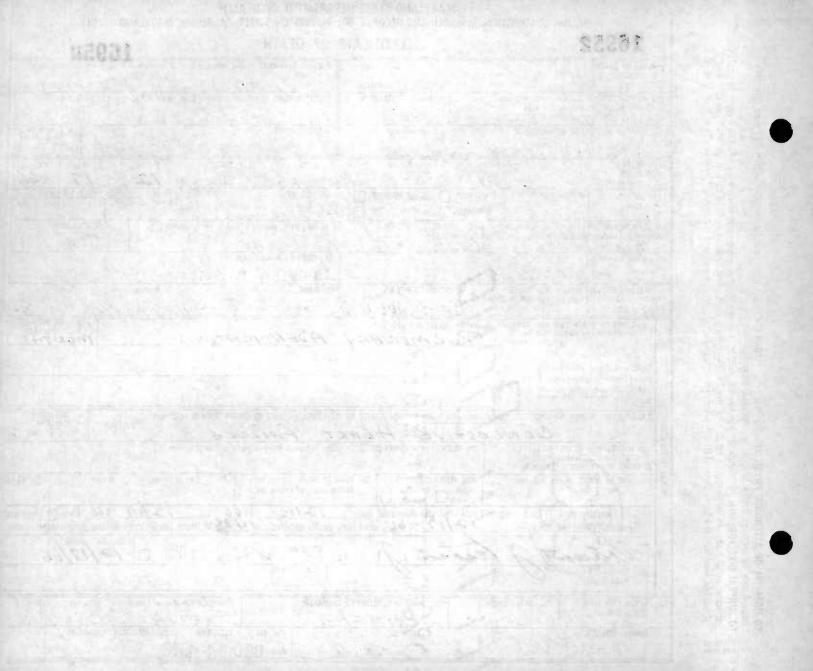
The second secon MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

KIND WESTERMITTER KTOL PARCE KERT WEST MINISTERS NEAR THRYSTORY NEIGH MAYBRORY NORH HARVEY BARIZON DEC WHITE - FEB. 14 / 882 94 3100 SELF-EMPLOYED CARROLLED. MD. 45 C. ARV PINEHART SWAZ 218-36-8635 Pay & SACKSON PLANTESS artinocoloute 918 0 ne - 12/7/616 The was a lead ordered will the live to committed and THE Robertson Head Windows, hat Wholise ON FORERESTON MO BURIAL 12/13/66 BRIST EMMANH CENETROY RURAL, WESTMINGTON, MIS 2 2 maps of proprientite, mile

1		DIVISION OF STATISTICAL RESEARCH A	ND RECORDS	ARTMENT OF 301 W. PRESTO	F HEALTH IN STREET, E	BALTIMORE 1.	MARYLAND
# 50° #			RTIFICATE				6949
deat deat	1.	PLACE OF DEATH a. COUNTY		2. USUAL RESIDEN	CE (Where deceased		Residence before admission
No.		Carroll	MARYLAND	a. STATE Mary	and	b. COUNTY Carr	oll
rs aftu by th Pages irs aft		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	H OF STAY IN 1b	c. CITY OR TOWN (II	outside corporat		L and give nearest town
in our		Rural-Westminster			L-Westmin	ster	06.1
4 9 6 7		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, gi	re street address)	d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?
		Caples Nursing Home					YES NO X
executed within and completely remove carbon prany event, with	3.	DECEASED	Middle	Last	4. DATE DF	Month	Day Year
od v	5	(Type or print) FANNTE. SEX 6. COLOR OR RACE 7. MARRIED NEVE	MAE	BATIEY DATE OF BIRTH	DEATH	12 E (In years IFUNDE	12 1966 R 1 YEAR IF UNDER 24 HR
and cor	1	NEVE / MARRIED NEVE	IN THE PROPERTY OF THE PARTY OF	5/5/89		t birthday) Months	
exect and remo				11. BIRTHPLACE (C	ounty & State or fo	yrs.	CITIZEN OF WHAT
cate be physician n please val, and iy	dur	. USUAL OCCUPATION (Give kind of work done Ing most of working life, even if retired) INDUSTRY	3114E33 OK			reign country) 12.	COUNTRY?
ate hysi	13.	HW1 FATHER'S NAME	1	North Caro			USA
certifica ding ph Then remova	34	Duhan WYTTHE Dataman	1000	Polly ?			
cer indii r rei	15.	Ruben RAXIAT Peterson Was DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SE	CURITY NO. 17.	INFORMANT		Address	
requires that the death certificate be ding physician. been signed by the attending physician the burial-transit permit. Then please or to burial, cremation, or removal, and		s, no, or unkown) (If yes give war or dates of service)	0673B Mr	. Hubert Ba	iley 1	Westminste	r. Md.
at the deat lan. d by the at ransit pern cremation,	T	18. CAUSE OF DEATH [Enter only one cause per line for (a),		12	Λ	1	I INTERVAL BETWEEN
that the sician. Sician. gned by tal-transitial, crema		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	12.1.11	Throng	Masin	acute	ONSET IND DEATH
law requires that tattending physician, has been signed be as the burial-tran h prior to burial, cre		4201 DUE TO (1)	5/1	1 1	0 1 1	. 11	1 50
physici physici n signed burial-t burial-t		Conditions, If any, which \ (b)	is olek	erole	Carle	5 bollet	a secons
requir ding p been the b		gave rise to immediate cause (a), stating the DUE TO	a-0. C	Kupa	10	4 4	years
ttendii has be as th prior	Z	underlying cause last. (c)	a De	upp 12	The state of the s		
	CERTIFICATION	PART II. OTHER SICHIFICANT CONDITIONS CONTRIBUTING TO D	EATH BUT MOTRELAT	TEN TO THE TERMINAL!	DISEASE CONDITIO	ON GIVEN IN PART 1(a	PERFORMED?
l: The large of a definition of the large of	IFIC/	Chronic Us	Muci	11		Don't III of Ibarra	YES NO
SICIAN: The hospital or s certificate ched for us pt. of Healt	ERT	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	HOW INJURY OCCU	RRED. (Enter nature o	f Injury In Part I	or Part II of Item 1	8.)
PHYSICIAN: the hospita this certifi detached fo e Dept. of H		20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCC	TIPPED 120a PLAC	E OF INJURY (Home, fa	arm, 20f. (City	or town) (C	ounty) (State)
	MEDICAL	Hour a.m. While Not V	/hile factor	y, street, office bldg., e	itc.)	or town) (o	ounty) (State)
od by t After d be d	×.	p.m. 19 at work at w		76	2/23 11 (7-17-10	
		21. I certify that (I) (this hospital) attended the desaw the deceased alive on 19	1010	death assured at	96 J. M. From +	he assume and an	\mathcal{L}_{2} , that (1) (we) las
R ATTENI e retaine RECTOR: 3 should with the		22a. SIGNATURE	and that	death occurred at	ATOM L		DATE SIGNED
DIR. be		William Mer	Ver M.D.	ATTENDING X	MED.	STAFF D. /2	2-12-66
may MAL I		22c. PHYS/CIAN'S NAME (Type)	CA P III.D.	22d. ADDRESS	. 1.1/	7.	11: 11:
o 4 Pild E		Marie (type)		1356 M	un Wel	stucu	wells ne
TO HOSPITAL OR ATTEN Page 4 may be retaine TO FUNERAL DIRECTOR: director, page 3 shoul should be filed with th	23a.	BURIAL, CREMATION, 23b. DATE THEREOF 23c. N REMOVAL (Specify)	AME OF CEMETERY	OR CREMATORY	23d. LOCAT	ON (City, town or c	ounty) (State)
E E . B	0.0	Burial 12/14/66 St.	Paul's Cem		Bal	to. Co.	Md.
WD ATE (A)	24.		DRESS	25a. RE	C'D BY REGISTRA		
VR A15 (4) \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		Tipton-Eline Fun. Home, Hamps	Lead, Md.	DATE	DEC 15	1866 fcc	carles Judge

words begins - Lucyk Construction of the contract o

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16952 CERTIFICATE OF DEATH death. requires that the death certificate be executed within 24 haurs after death physician and campletely filled in by the funeral ren blease remove carban papers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY _ MARYLAND b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) write RURAL and give nearest town) WESTMINISTER THENSTOWN d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES 🗍 NO F 3. NAME OF 4. DATE Last Manth Doy Year DECEASED 12 19 66 DEATH (Type or print) IF UNDER 24 HRS. S. SEX 9. AGE (In years IF UNDER 1 YEAR 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH Manths last birthdoy) Days DIVORCED WIDOWED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY HOUSEREEN ALBOT 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME WHITE 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address HAMPSTEAD (Yes, no, orunknawn) (If yes give war or dates af service) 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY: ULMONARY ADENOMATOSIS IMMEDIATE CAUSE (o) signed by DUF TO Conditions, if ony, which gove rise ta immediate cause (a), DUF TO stating the underlying couse the haspital ar attending TO FUNERAL DIRECTOR: After this certificate has been as the last. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? HEART NO X ONGESTIVE MILURE YES for 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour a.m. factory, street, office bldg., etc.) Not While . 1966 to 21. I certify that (I) (this hospital) attended the deceased from_ 12/10 12/17, 1966, that (1) (we) lost 2/17 1966, and that death occurred at 435 M, from causes and on the date stated above. sow the deceased olive on 220. SHONATURE 22b. DATE SIGNED **ATTENDING** uceux M.D. PHYS. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Wishmenes directar, shauld by 230 BURIAL CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) 17-20-66 PRING 24. FUNERAL DIRECTOR 2Sa. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) Milarles 20 M 1/66

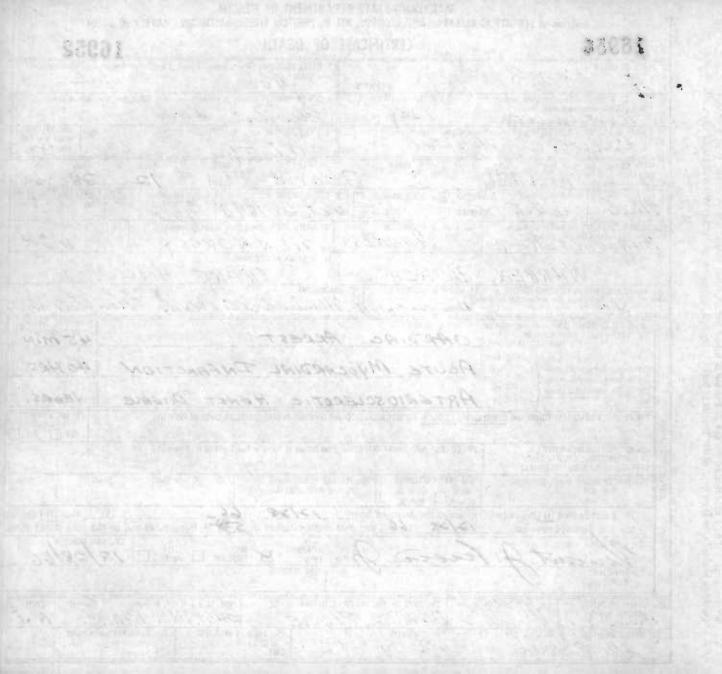


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16953 CERTIFICATE OF DEATH requires that the deoth certificate be executed within 24 hours ofter deoth deoth and completely filled in by the funeral remove corbon popers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? CARROLL CO. GENE YES NO A 3. NAME OF Lost 4. DATE Doy Year DECEASED JOHN 19 66 (Type or print) DEATH S. SEX IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR **NEVER MARRIED** lost birthdoy) Ooys Hours MARCH 25, 1885 WIDOWEO DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? please INOUSTRY BALTIMOREC FARMER

13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME the attending phy sit permit. Then IS. WAS OFCEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) 216-44-0134A 5 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) buriol-transit PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) signed by DUF TO Conditions, if ony, which gove rise to immediate couse (o), DUF TO stoting the underlying couse the hospital or ottending TO FUNERAL DIRECTOR: After this certificate hos been the last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) NO M for 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURREO 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) foctory, street, office bldg., etc.) TO HOSPITAL OR ATTENDING Page 4 may be retained by the ot work of work , 19 6 , to Dec 21 _____, 1966 , that (I) (we) last saw the deceased glive an 1966, and that death accurred at 3 3 M, from causes and an the date stated above 22o. SIGNATURE 22b. DATE SIGNED M.D. PHYS. DIRECTOR director, poge should be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) M. D. 23b. DATE THEREOF 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) REMOVAL-(Specify) ERECO BY REGISTRANGE 24. FUNERAL DIRECTOR 2Sb. REGISTRAR'S VR A15 (4)

清洁 古是 16603

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16954 CERTIFICATE OF DEATH law requires that the death certificate be executed within 24 hours ofter death physician ond completely filled in by the funeral en please remove corbon papers. Pages 1 and deat 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) PLACE OF DEATH a. COUNTY a. STATE b. COUNTY MARYLAND c. LENGTH OF STAY IN 16 b. CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If outside corporate lippits, write RURAL and give nearest town) write RURAL and give nearest town) IS RESIDENCE d. STREET ADDRESS (If not in hospital, give street address) YES NO in any event, within NAME OF First Middle DATE Month Day Year DECEASED OF 28 19606 (Type or print) DEATH SEX DATE OF BIRTH AGE (In years IF UNDER 1 YFAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED lost birthdoy) Months Hours Doys WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of warking life, even if retired) INDUSTRY. COUNTRY? and MEW VERS MANUFACTUR 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAMI or removol, the attending p 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO (Yes, na, ar unknawn) (If yes give wor ar dates af service) MoMallarde Beach cremotion, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) signed by the burial-transit p PART I. DEATH WAS CAUSED BY ARREST CARDIAC IMMEDIATE CAUSE (o) DUE TO burial, MYOCARDIAL INFARCTION 40 HRS Conditions, if ony, which gove rise to immediate cause (a). DUE TO prior to stating the underlying cause as the has been TERIOSCLEROTIC HEART VEARS last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPSY PERFORMED? NO O FUNERAL DIRECTOR: After this certificate YES PHYSICIAN: for 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) by the hospitol detached for (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth. Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) Hour a.m. Not While factory, street, office bldg., etc.) at wark should be 12/28,1966 10 21. 1 certify that (1) (this haspital) attended the deceased fram_ . 19___, that (I) (we) last be retoined and that death accurred at 5 3 M, fram causes and an the date stated abave. saw the deceased alive an 1966 220 SLOWATHRE 22b. DATE SIGNED ATTENDING director, page 3 should be filed v DIRECTOR PHYS. 22d. ADDRESS 22s. PHYSICIAN'S NAME (Type) 23o. BURIAL, CREMATION 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) BASILING 3/15/cING Tripace 250 REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66 Con recke DATE



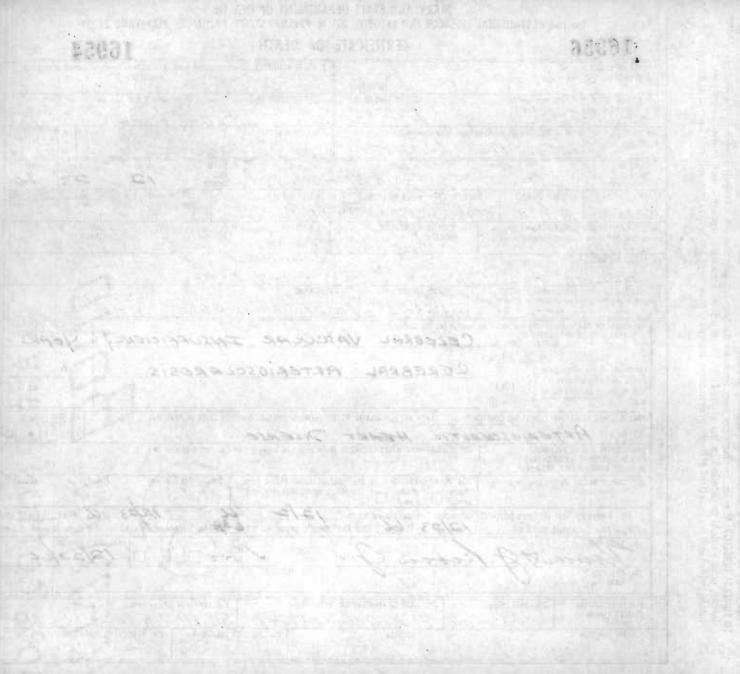
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

> VR ALS (4) 20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 16955 CERTIFICATE OF DEATH 16953

1	1.	PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
		CARROLL COUNTY MARYLAND	a. STATE b. COUNTY CARROLL
-		b. CITY OR TOWN (If outside corporate limits. 1/c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
	1	write RURAL and give nearest town 25 VRS.	WESTMINSTER DGI
	-	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	d. STREET ADDRESS e. IS RESIDENCE
٥		56 /2 JOHN STREET	56/2 JOHN STREET ON A FARM? YES NO NO
	3.	NAME OF First Middle DECEASED	Last 4. DATE Month Day Year
		(Type or print) LEANNA CATHEKIN	BROWN DEATH DEC F 1966
	5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8	B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Jast birthday) Months Days Hours Min.
		WIDOWED DIVORCED S	EPT. 6. 1903 63 yrs. Mortus Days Hours Mill.
	10a	USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?
	5	EAMSTRESS CLOTHING	CARROLL COUNTY U.S.A.
	13.		14. MOTHER'S MAIDEN NAME
	~	ESSIE LEVI-BROWN	ROSE RONE
	15 (Ye	. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17.	INFORMANT PS ALICE E S. Address
	(NO - 213-05-386'NSIS	TENTE 98 N. RALPH ST. WESTMINSTER MD
	Ī	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN
A		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Okleyas shago ONSET AND DEATH
		331X DUE TO OC -1	1-1 Severy
		Conditions, If any, which \ (b)	Teast arter of clean 415
		gave rise to immediate cause (a), stating the DUE TO	RYSigle
		underlying cause last. (c) Abd Luke	april 8-1963 Ken Plag.
	TION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA	TEN TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(4) 19. WAS AUTOPSY PERFORMED?
)	CERTIFICATION		YES NO NO
	RTIF	20a. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCU	RRED. (Enter nature of injury in Part I or Part II of Item 18.)
		(IF EITHER, NOTIFY MEDICAL EXAMINER)	
	MEDICAL	Hauri a factor	CE OF INJURY (Home, farm, 20f. (City or town) (County) (State) ry, street, office bidg., etc.)
	MED	Hour a.m. While Not While p.m. 19 at work at work)
H		21. I certify that (I) (this hospital) attended the deceased from 6	pril 8, 1963 tollect, 1966 that (1) (we) last
		saw the deceased alive on 1966, and that	death occurred at LODM, from the causes and on the date stated above.
		22a. SIGNATURE	ATTENDING - MED. STAFF 22b. DATE SIGNED
		Oflew Reicher M.D.	. PHYS. DIRECTOR PHYS. 1/2-2-66
1		22c. PHYSICIAN'S NAME (Type) DR 200 (EMA) S Dr 10 (15)	22d. ADDRESS
	1	MY W. CALINI SPETCHET	(133 E. MAIN SIC NES MINSTER, V.
	23a	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY	OR CREMATORY 23d. LOCATION (City, town or county) (State)
	24	FUNERAL DIRECTOR ADDRESS	1 25a. REC'D BY REGISTRAR I 25b. REGISTRAR'S SIGNATURE
	-	Tare B halled Librariants	DEC 5 1966 Charles Judge
5	12	umis a sayaut, NESIMINSTE	DATE DESCRIPTION OF THE PROPERTY OF THE PROPER

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16956 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death and completely filled in by the funeral remove carban papers. Pages 1 and the anv event. within 72 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) O. COUNTY CARROLL o. STATE b. COUNTY MARYIAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3 WEEKS IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS CARROLL OD GENERAL HOSPITAL MAPLE AVE YES NO Z 3. NAME OF First Middle Lost 4. DATE Month Doy Year DECEASED 23 BROWN 12 1966 (Type or print) DEATH S. SEX 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED lost birthdoy) Months WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT please during most of working life, even if retired) **INDUSTRY** COUNTRY? CARROLL CO. MD 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME NELSON A. ELLEN J. MAUS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address AVE AVE (Yes, no, or unknown) (If yes give wor or dates of service) MRS. GEO. L. GASSMAN 2/7-28-738 ESTMINITER MI 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN signed by the buriol-transit p PART I. DEATH WAS CAUSED BY: CEREBRAL VASCULAR INSUFFICIENCY IMMEDIATE CAUSE (o) DUE TO CEREBRAL Conditions, if ony, which gove ARTERIOSCLEROSIS rise to immediate couse (a). DUF TO stating the underlying couse O FUNERAL DIRECTOR: After this certificate has been the 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) TERIOSCIEROTIC YES NO <u>Lo</u> 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) detached f te Dept. af h OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) ot work 21. 1 certify that (1) (this haspital) attended the deceased fram. 12/23, 1966, that []) (we) last . 1966 . ta 12/23 1966, and that death accurred at 638 M, fram causes and an the date stated above saw the deceased alive on. 220. SHONATURE 22b. DATE SIGNED ATTENDING micens M.D. DIRECTOR PHYS 22d. ADDRESS 22c PHYSICIAN'S NAME (Type) directar, 23c NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (Stote) 24. FUNERAL DIRECTOR 250 REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4)



100	MAR DIVISION OF STATISTICAL RESE	YLAND STATE DEI ARCH AND RECORDS	PARTMENT OF I . 301 W. PRESTON	HEALTH STREET, BALTIMO	RF 1. MARYLAND
	16957		E OF DEATH		16955
M M M M M M M M M M M M M M M M M M M	PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE	(Where deceased lived, If ins	titution: Residence before admission	
	Carroll	MARYLAND	a. STATE Maryl		Carroll
	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b		otside corporate limits, wr	ite RURAL and give nearest town
- 3	Sykesville d. NAME OF HOSPITAL OR INSTITUTION (if not in h	Years lospital, give street address)	d. STREET ADDRESS	sorte, ma	e. IS RESIDENC
S	pringfield State Hospital		Main Stree	t	ON A FARM?
	NAME OF First DECEASED	Middle		4. DATE Month	
	(Type or print) Charlotte	nan Buck	ingham	OF DEATH 1 3	30 1966
	SEX 6. COLOR OR RACE 7. MARRIEO	THE REAL MINISTER	B. DATE OF BIRTH		IF UNOER 1 YEAR IF UNDER 24 HR Months Days Hours Min
	emale White WIOOWEO	DIVORCEO []	7-7-83	yrs. lity & State, or foreign country	
duri	ing most of working life, even if retired)	NDUSTRY			COUNTRY?
13.	FATHER'S NAME	Home	Marylan 14. MOTHER'S MAIDEN		U.S.A.
J	Dallas Shipley		Catherine	Fowler	
15.			INFORMANT	Addres	S
	No - 21	00 //00-/	ospital reco	rds	
	18. CAUSE OF DEATH [Enter only one cause per I PART I. DEATH WAS CAUSEO BY:	ine for (a), (b), and (c).]	00.	10.	INTERVAL BETWEEN ONSET ANO OEATH
	1/22 IMMEDIATE CAUSE (a)	ros. Hull	College	Jackers	
	Cenditions, If any, which	Visconi Asto	11: Bur O.	to Crede	in same a - Di
	gave rise to immediate cause (a), stating the DUE TO	wine pine	us. Ja xe	core cour	o macuos des
-	underlying cause last. (c)				
CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBU	UTING TO DEATH BUT NOT RELA	TED TO THE TERMINAL DIS	EASE CONDITION GIVEN IN	PART 1(a) 19. WAS AUTOPSY PERFORMED?
IFIC/	20a. ACCIDENT WAS UNDERLYING 1 20b.	DESCRIPE HOW INCOME OF	DDED (Fatan natura of la	de la Bank Las Bank II a	YES NO
CERT	OR CONTRIBUTING CAUSE OF OFATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	DESCRIBE HOW INJURY OCCU	KKED. (Enter nature of in	ijury in Part i or Part II o	r Item 18.)
		NJURY OCCURRED 20e. PLAC	E OF INJURY (Home, farm	, 20f. (City or town)	(County) (State)
MEDICAL	Hour a.m. While p.m. 19 at worl	- NOT WILLS	y, street, office bldg., etc.		
-	21. I certify that (I) (this hospital) attend		12-20 196	6 to 12 - 30	. 19 66. that (I) (we) las
	saw the deceased alive on 19-13				and on the date stated above
	22a. SIGNATURE	n10	ATTENOING ME	D. STAFF	22b. OATE SIGNEO
	22c. PHYSICIAN'S	///P M.D.	PHYS. DIR	ECTOR PHYS.	
1	NAME (Type) H. E. CON	DOR		State Hosp.,	Sykesville, Md
23a.	BURIAL, CREMATION, 23b. OATE THEREOF	23c. NAME OF CEMETERY	OR CREMATORY	23d LOCATION (City, to	wn or county) (State)
24	OUTIN 1-2-61	1 Ay lorsuille	- COMPLETE	CATTOIL	G- Md.
24.	FUNERAL DIRECTOR	ADORESS MA		BY REGISTRAR 25b. RE AN 4 1967	GISTRAR'S SIGNATURE JCharley Judge
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DWISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral hours after death. and PLACE OF OEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. COUNTY a. STATE b. COUNTY by the financial pages 1 are after MARYLAND b. CITY OR JOWN (if outside corporate limits. C. LENGTH OF STAY IN 1b (If outside corporate limits, write RURAL and give nearest town) ve carbon papers. Pag event, within 72 hours write RURAL and give nearest town) = filled d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) IS RESIDENCE 24 DN A FARM? YES executed within completely NAME OF First Middle Last 4. DATE Month Day Year DECEASED DF (Type or print) Ra DEATH 6. COLDR DR.RACE SEX DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. remove 9. 7. MARRIED NEVER MARRIED last birthday) any Months Davs Hours and WIDDWED 2 DIVORCED [10a. USUAL OCCUPATION (Give kind of work done physician and ph = 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? SEAM STRE 13. FATHER'S NAME death certificate removal, MDTHER'S MAIDEN NAME attending physimit. Then, 15. WAS DECEASED EVER IN U.S. ARMED FORCES? ned by the attend il-transit permit. al, cremation, or r 16. SOCIAL SECURITY NO. INFDRMAN' 17. Address (Yes. no, or unkown) (If yes give war or dates of service) CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] 18. INTERVAL BETWEEN ATTENDING PHYSICIAN: The law requires that the DNSET AND DEATH PART I. DEATH WAS CAUSED BY: the hospital or attending physician. IMMEDIATE CAUSE (a) signed been signed the burial-trainer to burial, c DUE TO Conditions, If any, which (b) gave rise to immediate DUE TD cause (a), stating the prior underlying cause last. has as (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY for use Health PERFORMED? certificate YES this cerum detached fo 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NDTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part 1 or Part 11 of Item 18.) be detached State Dept. MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) should be de factory, street, office bldg., etc.) Hour a.m. While Not While p.m. 19 at work at work retained 21. I certify that (1) (this hospital) attended the deceased from DIRECTOR: Jage 3 should lied with the saw the deceased alive and that death occurred at 1/1 1/2. M. from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED TO FUNERAL DIRE director, page 3 should be filed v pe ATTENDING MED. DIRECTOR M.D. PHYS. PHYS. Page 4 may O HOSPITAL 22C. PHYSICIAN'S 22d. ADDRESS NAME (Type) BURIAL, CREMATION, NAME OF CEMETERY OR CREMATORY 23d. 23a. 23b. DATE THEREOF 23c LOCATION (City, bown or county) (State) REMOVAL (Specify) Er wheat FUNERAL DIRECTOR **ADDRESS** REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR AI5 (4)

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MARYLAND STATE DEPARTMENT OF HEALTH

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16959 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after deoth by the funeral Pages 1 and 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b. COUNTY Carrell MARYLAND Allegany s. write RURAL and give nearest town) c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If autside carparate limits, CITY OR TOWN (If autside carparate limits, write write RURAL and give nearest town) 3Yrs. 5mo. 6days Sykesville Cumberland popers. hin 72 ho d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital YES NO T 508 Woodside Ave corbon 3. NAME OF Middle 4. DATE Manth Year DECEASED (Type or print) Minnie Elizabethn Cessna 12 66 19 DEATH S SFX 8. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 9. AGE (In years 7. MARRIED NEVER MARRIED ottending physician and composermit. Then please remove on, or removal, and in any eve last birthdoy) Manths 3-21-88 Female White WIDOWED K DIVORCED 10a. USUAL OCCUPATION (Give kind of wark done 10b, KIND OF BUSINESS OR 11. DIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life even if retired) Housewife & Landlady INDUSTRY COUNTRY? Rooming house Somerset Co. Penna. 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Henry J. Knieriem Annie Sipple 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, na, ar unknawn) (If yes give war ar dates af service) Records. Springfield State Hospital 214-32-3362 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN signed by the buriol-tronsit p PART I. DEATH WAS CAUSED BY: ONSET AND DEATH Myocard Infarction IMMEDIATE CAUSE (a) DUF TO Arteriosclerotic Heatt Disease Conditions, if ony, which gave rise ta immediate couse (a), DUF TO stating the underlying couse O FUNERAL DIRECTOR: After this certificate hos been the Heolth prior to 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) USe NO X for 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) foctory, street, office bldg., etc.) Hour a.m. Not While at work at work 21. I certify that (I) (this haspital) attended the deceased fram 7-19-63 and that death accurred at 10 PM, fram causes and an the date stated above. saw the deceased glive an_ 22b. DATE SIGNED 22a, SIGNATURE STAFF PHYS. ATTENDING MED. DIRECTOR director, poge 3 should be filed v M.D. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S Sukesville NAME (Type) 23a. BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) BREMOVAL (Specify) 12/29/66 Hillcrest Burial Park Cumberland, Allegany Md. 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS 2So. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66 Ochoneles H. Wayne George Cumberland, Maryland 1056 TDATEC 2 A

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16960 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. and campletely filled in by the funeral remave carbon papers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) d. COUNTY Carroll a. STATE b. COUNTY MARYLAND Baltimore City c. CITY OR TOWN (If outside carporote limits, write RURAL and give nearest town) b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 16 write RURAL ond give neorest tawn)
Sykesville on papers. Pag within 72 hours Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 2308 Druid Hill Avenue Springfield State Hospital NO IN 3. NAME OF Middle 4. DATE First Last Day Year DECEASED 24 VELMA CORNETT 66 (nmn) 19 (Type ar print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE B. DATE OF BIRTH AGE (In years 7 MARRIED NEVER MARRIED age remave birthday) Manths Days Haurs 11-5-23 Negro Female WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind af wark dane during mast af warking life, even if retired) 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT INDUSTRY **COUNTRY?** Virginia

14. MOTHER'S MAIDEN NAME Domestic II.S.A 13. FATHER'S NAME Dennis Lomax Bessie Wiggins 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, ng_ar unknawn) (If yes give war ar dates af service) Unknown Records, Springfield State Hospital 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-transit ONSET AND DEATH Bronchopneumonia IMMEDIATE CAUSE (a) signed by DUE TO Canditians, if any, which gave Nutritional Cirrhosis of Liver Years rise ta immediate cause (a), DUE TO stating the underlying cause TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital ar attending TO FUNERAL DIRECTOR: After this certificate has been use as the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Chronic brain syndrome associated with central nervous system syphilis meningovascular, with psychotic reaction. Alcoholism (addiction). 19. WAS AUTOPSY PERFORMED? YES DE NO far 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20g. ACCIDENT WAS LINDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City ar tawn) (Caunty) (State) Hour a.m. Nat While factory, street, affice bldg., etc.) at wark at wark , ta 12/21/66, 19__, that (I) (we) last 21. I certify that (1) (this haspital) attended the deceased fram_ 11-9-65 .19 shauld saw the deceased alive an 12/21/66 and that death accurred at 7:15PM, fram causes and an the date stated above. 22a. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. DIRECTOR PHYS. PHYS. directar, page shauld be filed 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S NAME (Type) Sykesville, Maryland Ronald N. Kornblum shauld 23b. DATE THEREOF 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY (State) 23a. BURIAL, CREMATION, (County) REMOVAL (Specify)
Burial Baltimore, Maryland
EGISTRAR 25b. REGISTRAR'S SIGNATURE 12-29-66 Auburn Cem, 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR **ADDRESS** VR A15 (4) Minley Judge DATE

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16961 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death and campletely filled in by the funeral remave carban papers. Pages 1 and n any event, within 72 hours after deat PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY Carroll o. STATE b. COUNTY MARYLAND Maryland Maryland Montgomery
c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Sykesville c. LENGTH OF STAY IN 1b 2vr.2mos.ldv. Silver Spring d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? NO T Springfield State Hospital 8407 Cedar Street YES 3. NAME OF Middle 4. DATE Doy Year DECEASED EDWARD ALEXANDER COTTRELL December 13 (Type or print) DEATH S. SEX 9. AGE (In years lost birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED B. DATE OF BIRTH NEVER MARRIED Manths Days Haurs Male WIDOWED DIVORCED 7-4-1880 White 10o. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Caunty & State, or fareign cauntry) 12. CITIZEN OF WHAT during most of working life, even if retired)
Blacksmith COUNTRY? please INDUSTRY ond Delaware 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remayal, the attending phys Mary Alexander Ball Isaac Benjamin Cottrell 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (Yes_no_or unknawn) (If yes give war or dotes of service) 220-54-6700 Records, Springfield State Hospital crematian, INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: signed by the burial-transit p ONSET AND DEATH IMMEDIATE CAUSE (a) Bronchopneumonia Days physician. DUF TO Canditians, if any, which gave (b) Carcinoma of prostate gland Months rise to immediate cause (o), DUF TO has been s stating the underlying cause as the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) Chronic brain syndrome associated with alcoholism with behavioral reaction. 19. WAS AUTOPSY PERFORMED? YES X NO O FUNERAL DIRECTOR: After this certificate 4 may be retained by the hospital ar for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 1B.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or tawn) (County) (State) 20c. TIME OF INJURY Month, Doy, Year Hour a.m. Not While foctory, street, office bldg., etc.) ot work at work saw the deceased glive an 12-13-66 19 and that death accurred at 15 m, from causes and an the data statute as SIGNATURE shauld 22a. SIGNATURE **ATTENDING** STAFF PHYS. X 12-13-66 director, page 3 shauld be filed v M.D. DIRECTOR 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz. M.D. Sykesville, Maryland 2178h 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL CREMATION. (County) (State) REMOVAL (Specify) ORESTOWN. 24. FUNERAL DIRECTOR ASO, REC'D BY REGISTRAR 25b, REGISTRAR'S SIGNATURE Marley VR A15 (4) 20 M 1/66 BEC

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAN FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. COUNTY a-STATE b. COUNTY Allegany Carroll MARYLAND Maryland lay is necessary, 13 to the funeral Page 5 may be Department after death. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3mos.6dys. Cumberland Sykesville d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? State hours Springfield State Hospital 1301 Oldtown Road NO T YES NAME OF Middle-Month Last DATE Day Year DECEASED (Type or print) DEATH HARVEY CLEVELAND CROFT DECEMBER 2 with within after death. If a Give Pages 1, ong with form 5. SEX 6. COLOR OR RACE | 7. MARRIED AGE (In years | IFUNDER 1 YEAR | IFUNDER 24 HRS | last birthday) | Months | Days | Hours | Min. DATE OF BIRTH NEVER MARRIED 10-25-1884 WIDOWED DIVORCED [White event 10a. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (State or foreign country) during most of working life, even if retired) COUNTRY? Farmer (retired) pages 1 Maryland U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 24 hours in Item 18. Alexander Croft Ellen (last name unk.) File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address 16. SOCIAL SECURITY NO. should be executed within 29 word "pending" in pencil in Chief Medical Examiner's 0: (Yes, no, or unkown) (If yes give war or dates of service) permit. removal, 213-18-2706 Records, Springfield State Hospital Unk. INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c),] burial-transit proceeds or proceed or proceeds or proc PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). Uremia Days DUE TO Nephrosclerosis Months Conditions, If any, which gave rise to immediate DUE TO cause (a), stating the used as a to burial, (CO Generalized arteriosclerosis underlying cause last. Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? Fracture, neck of left femur NO X YES T be 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part 1 or Part 11 of Item 18.)
Fell to floor, could not get up by himself. 20a. EXTERNAL CAUSE WAS PRIMARY TO OF CONTRIBUTING A CAUSE OF DEATH. should l MEDICAL 20c. TIME OF INJURY Month, Day, Year | 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, Springfield State Hospital ward G-1, dining area. Men's Group 38 11-2- 19 66 at work Nof While Ward Sykesville. Carroll 21. I certify that I took charge of the remains described above, held an Autopsy Inspection X, Inquiry and In my opinion Undetermined manner death resulted from: Natural causes Suicide Homicide Accident CHIEF MEDICAL EXAMINER YOUR execute r. Page 4 d for you 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE 10 E. Main Westminster Maryland 12-15-66 Health **EXAMINER'S** please en director. retained Glenn Speicher. NAME (Type) BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 23d. LOCATION (City, town or county) 23c. NAME OF CEMETERY OR CREMATORY (State) 0 Garrett County, Md. Dec. 18 166 Mt. Zion Cemetery Burial REC'D BY REGISTRAR (25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Joseph R. Burst, Sr., Frostburg, Md. VR A15ME 3500 4-64

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# 5 5 DIVORCED DIVORCED Y 1 - 1082 Y yrs.	Residence before admission
b. CITY OF TOWN (if outside corporate limits, write RUR) write RURAL and give nearest town d. NAME OF JOSPITAL OF INSTITUTION (if not in hospital, give street address) d. NAME OF JOSPITAL OF INSTITUTION (if not in hospital, give street address) 3. NAME DF FIRST Middle Ast (FUT h) DECEASED (Type or print) (Type or print) 5. SEX 6. COLOR OR RACE / MARRIED NEVER MARRIED S. DATE OF BIRTH 103. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 104. WIDOWED DIVORCED 7. 1882 105. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 11. BIRT HPLACE (County & State, or foreign country) 12. MOTHER'S MAIDEN, NAME 14. MOTHER'S MAIDEN, NAME	e. IS RESIDENCE DN A FARM? YES Day Year 19 DER 1 YEAR IF UNDER 24 HRS S Days Hours Min.
Write/RURAL and give nearest town d. NAME OF HOSPITAL OF INSTITUTION (If not in hospital, give street aggress) d. STREET ADDRESS d. STREET ADDRESS A. DATE DECEASED (Type or print) S. BEX G. COLOR OR RACE WIDOWED DIVORCED 103. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 13. FATHER'S NAME 14. MOTHER'S MAIDEN, NAME 14. MOTHER'S MAIDEN, NAME	e. IS RESIDENCE DN A FARM? YES NO DAY YEAR 19 DAY PORT 1 YEAR 1 FUNOER 24 HRS S Days Hours Min.
3. NAME DEPOSE THAT OF INSTITUTION IT HOS IN HOSSING, give street address d. STREET	DN A FARM? YES NO PORT 19 PORT 1 YEAR IFUNOER 24 HRS Min. CITIZEN OF WHAT
3. NAME DF DECEASED (Type or print) NAOM NEVER MARRIED S. BEX 6. COLOR OR MACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UND) Months 102. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRT HPLACE (County & State, w foreign country) 12. 13. FATHER'S NAME 14. MOTHER'S MAIDEN, NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, pr unkown) (If yes give war or dates of service) 16. SDCIAL SECURITY NO. 17. INFORMANT 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c),]	19 66 DER 1 YEAR IFUNDER 24 HRS IS Days Hours Min.
S. SEX 6. COLOR OR RACE MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years lif under the sext divinday) Months	CITIZEN OF WHAT
103-TOSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 103-TOSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 11. BIRTHPLACE (County & State, & foreign country) 12. MOTHER'S MAIDEN, NAME 13. FATHER'S NAME 14. MOTHER'S MAIDEN, NAME 15. WAS DECEASED EVER IN U.S. ARMED FOREST (Yes, no., or unknown) (If yes give war or dates of service) 16. SDCIAL SECURITY NO. 17. INFORMANT (Yes, no., or unknown) (If yes give war or dates of service) 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), 1	COUNTRY?
13. FATHER'S NAME 14. MOTHER'S MAIDEN, NAME 15. WAS DECEASED EVER IN U.S. ARMED FDRGES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SDCIAL SECURITY NO. 17. INFORMANT 17. INFORMANT 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), 1	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SDCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c),]	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c),]	sville, Md.
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b)	INTERVAL BETWEEN ONSET AND DEATH
Conditions, if eny, which (b) Seal Carella Variellas	P
cause (a), stating the DUE TO underlying cause last. (c)	,
	(a) 19. WAS AUTDPSY PERFORMED? YES NO
	18.)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Not While at work at work at work	County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 to 19 saw the deceased alive on 19 to 1	
22a. SIGNATURE ATTENDING MED. STAFF 22b. M.D. PHYS. DIRECTOR PHYS. 22d. ADDRESS NAME (Type) A A S T A A A A A A A A A	DATE SIGNED
22c. PHYSICIAN'S NAME (Type) A 3 22d. ADDRESS 22d. ADDRESS 23d. LOCATION (City, town or common process) 23d. Location (City, town or common process) 23d. Location (City, town or common process)	unslehm
Saw the deceased alive on 19 c, and that death occurred at M. from the causes and on 22a. SIGNATURE 22c. Physician's NAME (Type) 23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR GREMATORY 23d. LOCATION (City, town or or of the complete of the complet	Md.
5 (4) W Harry W. Haight Sykesville, Md. DATE DEC 7. 1966 JCL	iarles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 16964 requires that the death certificate be executed within 24 hours after death. filled in by the funeral pages 1 and 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH a. COUNTY h COUNTY a. STATE Balto. City Carroll MARYLAND Marvland c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn) Baltimore Sykesville, Md. h yrs. 28days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 7528 Holabird Ave. YES NO DE Springfield State Hospital carbon 3. NAME OF Middle 4. DATE Manth Lost Day Year (Alvernia) DECEASED Almeda 18 19 66 Dawis December Carolina DEATH (Type or print) IF UNDER 24 HRS IF UNDER 1 YEAR 9. AGE (In years S. SEX 6. COLOR OR RACE 8 DATE OF BIRTH 7. MARRIED NEVER MARRIED birthday) Months Days Hours ony 11-22-79 WIDOWED DIVORCED Female White 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, ar fareign country) 12. CITIZEN OF WHAT physician or ten pleose r during most of working life, even if retired)

Housewife COUNTRY? INDUSTRY West Virginia U.S.A. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME or removal, Isac Bell Almeda Stemple 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address (Yes, no. ar unknown) (If yes give war or dates of service) Hospital Records No None cremation, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter anly one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: signed by the buriol-tronsit p burial, cremation ONSET AND DEATH C.V.A. IMMEDIATE CAUSE (a) by the hospitol or attending physician. DUE TO Cerebral Arteriosclerosis Years. Canditions, if any, which gave rise to immediate cause (a), DUE TO Chronic brain syndrome associated with cerebral Years. stating the underlying couse **TO FUNERAL DIRECTOR:** After this certificate has been director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior to arteriosclerosis with psychotic reaction. PHYSICIAN: The law 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO to 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Port II af item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) Not While foctory, street, office bldg., etc.) at wark at wark 12.62 to 12- 18 , 19 66 that (I) (we) last 21. I certify that (I) (this haspitol) attended the deceased from 11-20-1966, and that death occurred at 2004 M, from couses and on the date stated above. TO HOSPITAL OR ATTEND Poge 4 moy be retoined 12-18 saw the deceased alive an_ 22b. DATE SIGNED 22a. SIGNATURE ATTENDING M.D. DIRECTOR PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Sykesville, Maryland Ilse Kamm 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Tawn) (County) (State) 23o. BURIAL, CREMATION REMOVAL (Specify)
Burial 12/21/66 Baltimore, Maryland Gardens of Faith 256. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) Robert C. Altenburg - 6009 Harford Rd. 20 M 1/66 Funeral Home, Inc.

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MARYLAND STATE DEPARTMENT OF HEALTH <u>DIVISION</u> OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND 6965 CERTIFICATE OF DEATH 24 hours after death. and PLACE OF OEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY Pages 1 b. COUNTY arro 11 MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH CF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) write RURAL end give nearest town) months = anchesto carbon papers. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE filled d. STREET ADDRESS ON A FARM? UISING NO C YES within etely 3. NAME OF DATE Month Middle Last 4. Day Year DECEASED event, comple (Type or print) recember a DEATH 1966 executed SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years | IF UNOER 1 YEAR | IF UNOER 24 HRS. 8. remove 7. MARRIED NEVER MARRIED last birthday) Months | Days Hours any and WIOOWEO L DIVORCEO 2 10a. USUAL OCCUPATION (Give kind of work done) 10b. KINO OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) and INDUSTRY COUNTRY? touse wi ound land 45 A certificate the attending physit permit. Their ple nation, or removal, a 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address INFORMANT 17. death (Yes, no, or unkown) | (If yes give war or dates of service) been signed by the attention the burial-transit permits or to burial, cremation, o NUTSING mao INTERVAL BETWEEN ONSET AND DEATH CAUSE OF DEATH [Enter only one cause The law requires that the PART I. DEATH WAS CAUSED BY: attending physician. IMMEDIATE CAUSE (a) DUE TO Cenditions, If any, which gave rise to immediate as the prior to DUE TO cause (a), stating the underlying cause last. (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY use for use Health certificate PERFORMED? the hospital or 20b. OESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) YES T NO T 20a. ACCIDENT WAS UNDERLYING OF OR CONTRIBUTING CAUSE OF OEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) PHYSICIAN: this certif detached for 3 Dept. of 1 MEDICAL TIME OF INJURY Month, Oay, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, (County) (State) 20f. (City or town) det D D factory, street, office bldg., etc.) Hour a.m. Not While After While be at work at work p.m. retained P 21. Lecertify that (I) (this Mospital) attended the deceased from that (I) (we) last DIRECTOR: age 3 should filed with the saw the deceased alive o and that death occurred at M. from the causes and on the date stated above. 22a. \$1GNATURE 22b. DATE SIGNED pe page ATTENOING PHYS. DIRECTOR M.D. O HOSPITAL TO FUNERAL PHYSICIAN'S 22d. ADORESS director, p NAME (Type) BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) ouria 24. FUNERAL DIRECTOR AODRESS 25b. REGISTRAR'S SIGNATURE 25a REC'O BY REGISTRAR VR A15 (4) 20M 1/65

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1/ 100	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	16966 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
HEALTH DEPT.	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
that be and the	MARYLAND WARVLAND WARROLL
is necessary, to the funeral ce 5 may be Department after death.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
nece the f 5 m 5 m	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
delay is nd 3 to Page . State [State [hours a	KURAL MCKINISTRYS MILLS RURAL YES NO U
dela 3. F 3. F bou	3. NAME OF DECEASED First Middle Lest 4. DATE Month Day Year
f any c 1, 2, ar PM3. Th the in 72	(Type or print) I SOM FUGENT I JEAN DEATH JJEC 23, 1966
ith. If all form P form P within	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years lif UNDER 1 YEAR IF UNDER 24 HRS last blinday) Months Days Hours Min.
with with	10a. USUAL OCCUPATION (Give kind of work done of work done of working life, even if retired) 10b. KIND OF BUSINESS OR II. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY2
after Giv	STUDENT COLLEGE MARYLAND US
n 18. Ge along pages In any	13. PATHER'S NAME 14. MOTHER'S MAIDEN NAME
24 ho Trice office and	15. WAS DECEASED EVER INU, S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address
within 2 pencil ir miner's permit.	(Yes, no, or yeloyln) (If yes give year or dates of service) 218-441-9841 MRS. LAENIS D. BARNEY. BALTIMORE ME
d wild amin amin t per	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), 1 PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH
uld be executed i "pending" in sf Medical Exan a burial-transit cremation, or	976 XIMMEDIATE CAUSE (a) JULIAN TO DUE TO DUE TO CHARLES TO THE T
e exe endir edica rial-tu matic	Conditions, If any, which gave rise to immediate (b)
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ficate shoul the word to the Chief or the Chief used as a to burial,	YES NO X
ch: This certificate, writing forwarded to 3'should be agent, prior to agent, prior to agent, prior to the control of the cont	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? YES NO 20a. EXTERNAL CAUSE WAS PRIMARY DO OF CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW MIJERY OCCURRED (Enter nature of injury in Part 1 or Part 11 of Item 18.) CAUSE OF DEATH.
This wr ward	20c. TIME OF INJURY Month, Day, Year, 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State)
AL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be files. These should be used as a burial-transit permit. File pages 1 and 2 with the State Department designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.	20c. TIME OF INJURY Month, Day, Year, 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) 2. Hear a.m. 12/23 (While Not While at work at work at work at work)
DEPUTY MEDICAL EXAMINE lease execute the certific rector. Page 4 should be stained for your files. FUNERAL DIRECTOR: Page I Health or its designated	21. I certify that I took charge of the remains described above, held an Autopsy, Inspection X, Inquiry, and in my opinion
IL EXA	death resulted from: Natural Causes , Accident , Suicide , Homicide , Undetermined manner .
MEDICAL tecute the Page 4 s for your f	ACTUAL SIGNATURE ALL SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER (1998) DATE SIGNED
Y MI exec Pa for for the	EXAMINER'S LAC CLEAN DEPUTY MEDICAL EXAMINER X
o DEPUTY MEDICA please execute to director. Page 4 retained for your of Health or its d	NAME (Type) X/Y (The E/Y M/) PE/CHEX Address X Screen and recounty milling control
d diagraph of	PREMOVAL (Specify) 12-27-66 WINTERS (FM. CARROLL COUNTY MAN
WD ASTAIR (b)	FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE ADDRESS 7 1966
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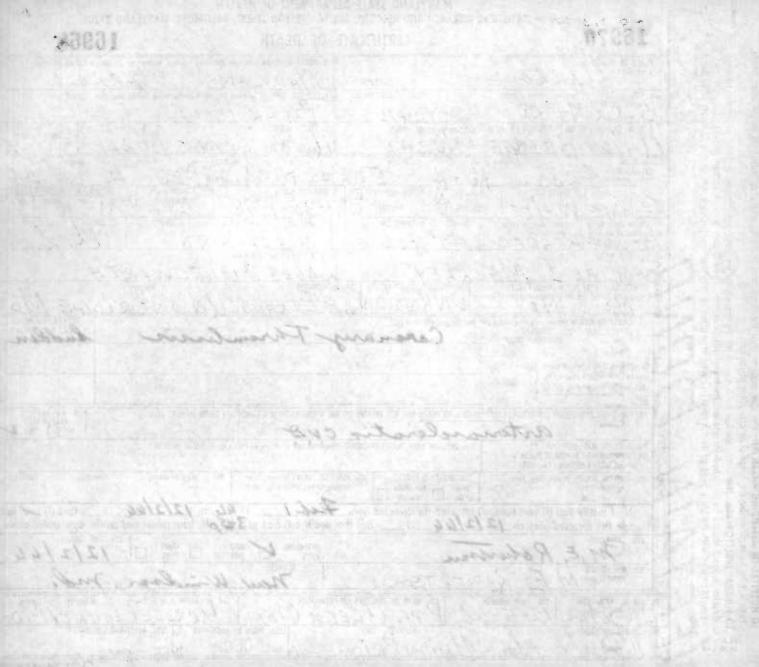
E 7 E	16968 CERTIFICAT	E OF DEATH	6966 /
1 and 2 er death	1. PLACE DF DEATH a. COUNTY Carroll MARYLANO	2. USUAL RESIDENCE (Where deceased lived, If institution: la. STATE b. COUNTY Maryland	Residence before admission
hours aft	b. CITY OF TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENCTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURA)	and give nearest town
	Sykesville	Baltimore City	30.4
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital	d. STREET ADDRESS 5105 Arbutus Ave.	e. IS RESIDENCE DN A FARM? YES NO
	3. NAME DF First Middle DECEASED	Last 4. DATE Month	Oay Year
_	(Type or print) TDA MANNIN DENNIS	DEATH December 25	19 66
	7. MARKIEO Z. NEVER MARKIED	8. DATE DF BIRTH 12-25-98 9. AGE (In years IFUNDER last birthday) 68 yrs.	Days Hours Min.
	1Da. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INOUSTRY	11. BIRTHPLACE (County & State, or foreign country) 12. C	ITIZEN OF WHAT
	Housewhife At Home	Russia	U.S.A.
	13. FATHER'S NAME	14. MOTHER'S MAIOEN NAME	
	Sol Radin	Celia ?	
	15. WAS DECEASED EVER IN U.S. ARMED FDRCES? 16. SOCIAL SECURITY ND. 17. (Yes, no, or unkown) (If yes give war or dates of service)	INFDRMANT Address	
		cords of Springfield State Hos	pital
I	18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	collages	11
	422. DUE TD 111	0 11 7	years.
	conditions, If any, which gave rise to immediate (b)	a.V.D.	3)
ļ	cause (a), stating the OUE TO		
ı	underlying cause last. (c)	ATER TO THE TERMINAL CHEST OF COMMITTEE AND	IAO WAR AUTORY
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELIGIOUS CONTRIBUTING TO DEATH BUTNOT RELIGIOUS CONTRIBUTING TO THE CONTRIBUTION TO THE CONTRIBUTI	mcertain cause w/nsychotic res	YES NO
	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HDW INJURY DCCI DR CONTRIBUTING 20USE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	URRED. (Enter nature of Injury In Part I or Part II of Item 1	3.)
		ACE OF INJURY (Home, farm, 2Df. (City or town) (Co	unty) (State)
	Hour a.m. While Not While p.m. 19 at work at work	pry, street, office bldg., etc.)	unity (state)
	21. I certify that the tension attended the deceased from	11-30-66, 19, to 12/2r/, 19	66, that (1) (we) las
		t death occurred at 10 45 RM, from the causes and on	
	22a. SIGNATURE Army M. D	O. PHYS. MEO. STAFF NO. 12	DATE SIGNED 1966
	22c. PHYSICIAN'S NAME (Type) ADNAN SONMEZ	Springfield State Hospital	Sykonville, 21)
	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME DF CEMETER REMDVAL (Specify)		
J	Burial 12/27/66 Oheb Shalom 24. FUNERAL DIRECTOR AGORESS	Baltimore, M. 1 25a. REGISTRAF 25b. REGISTRAF	S SICNATURE
	Sol Levinson & Bros. Inc., 6010 Reister	stown BEC 28 1966 Acharles	Judge
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DIVISION OF STATISTICAL RESEARCH AND RECORDS. 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission) e. COUNTY b. COUNTY d d d MARYLAND b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest (own) 6 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give streat address) d. STREET ADDRESS . IS RESIDENCE ON A FARM? YES NO NAME OF Middla DATE Month Year DECEASED OF (Type or print) DEATH 1966 6. COLOR OR RACE A MARRIED NEVER MARRIED DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months WIDOWED IV DIVORCED 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) 13. FATHER'S NAME 14. MOTHER MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMAN Address (Yes, no, or unkown) | (If yes give wer or datas of service 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BÉTWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gava rise to immadiate causa DUE TO (a), stating the undarlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING ERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY CATION PERFORMED? NO TO CERTIFI 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of itam 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Homa, farm, Month, Day, Yaar 20f. (City or town) (County) (Stata) fectory, streat, offica bldg., atc.) Whila Not Whila Hour a.m. et work et work p.m saw the deceased alive on..... . and that death occurred at. QM, from the causes and on the date stated above. 22b. DATE 22a. SIGNATURE ATTENDING SIGNED M.D. PHYS. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Typa) 23a. BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (Stata) REMOVAL* (Specify) 0 158. REC'D BY REGISTRAR 256 REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATUR

ARYLAND STATE DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16970 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. eoth funeral 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY ARROLL MARYLAND adse remave carban papers. Pages 1 and in any event, within 72 haurs affer CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1h c. CITA OR TOWN (If autside corparate limits, write RURAL and give nearest town) .⊑ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? filled i NO IX YES NAME OF Middle DATE Doy Year DECEASED OF DEATH (Type or print), IF UNDER 1 YEAR IF LINDER 24 HRS 6. COLOR OR RACE AGE (In years last birthdoy) NEVER MARRIED Months Dovs Hours WIDOWED DIVORCED 10o., USWAL OCCUPATION (Give kind of work done KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 10b. during most of working life, even if retired COUNTRY FATHER'S NAME 14 MOTHER'S MAIDEN NAME ar remove WORTH WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, orunk gown) (If yes give war or dates of service) burial, crematian, CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO signed t Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse State Dept. of Health prior to lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? NO O HOSPITAL OR ATTENDING PHYSICIAN: 1 Page 4 may be retained by the haspital ar YES FUNERAL DIRECTOR: After this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour a.m. Not While foctory, street, office bldg., etc.) ot work ot work 19 46, to 12 12/66, 19_, that (1) (we) last 21. I certify that (I) (this hospital) attended the deceased from. director, page 3 shauld should be filed with the and that death occurred at 345 pM, from causes and on the date stated above. saw the deceased alive on 12/2/46 19 22o. SIGNATURI 22b. DATE SIGNED ATTENDING M.D. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) 23b. (County) (Stote 2 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) DEC 20 M 1/66 DATE



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STA MEDICAL EXAMINER'S CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution PLACE OF DEATH a. COUNTY e. STATE b. COUNTY ROL MARYLAND he funeral may be Department after death. b. CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If outside corporete limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b write RURAL and give nearest town) the d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address d. STREET e. IS RESIDENCE ON A FARM2 any delay is 2, and 3 to t PM3. Page State YES NO NAME DE First Middle DATE Month Day Year Last DECEASED OF (Type or print) DEATH 2 with within 24 hours after death. If no ltem 18. Give Pages 1, Office along with form 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS **NEVER MARRIED** last birthdey) Months Davs Hours WIDOWED IX DIVORCED event 10d. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INDUSTRY 12. CITIZEN OF WHAT 11. BIRTHPLACE (State or foreign country) COUNTRY? \neg pages I 13. FATHER'S NAME MOTHER'S MAIDEN NAME File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT LATER SAND (Yes, no, or unkown) (If yes give war or dates of service) permit. removal, AL EXAMINER: This certificate should be executed within the certificate, writing the word "pending" in pencil is should be forwarded to the Chief Medical Examiner's 18. CAUSE DF DEATH [Enter only one cause per/line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: cremation, or IMMEDIATE CAUSE (a) DUF TO Conditions, if any, which (b) gave rise to immediate DUE TO cause (a), stating the ta underlying cause last (c) used as to burial 19. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION PERFORMED? NO V YES be 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part 1 or Part II of Item 18.) PRIMARY | or CONTRIBUTING | 9 2 CAUSE OF DEATH. shoul 3 shou MEDICAL 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) TIME OF INJURY Month, Day, Yeer factory, street, office bldg., etc.) Hour a.m. While Not While CTOR: Page designated at work at work Inquiry and in my opinion 21. I certify that I took charge of the remains described above, held an Autopsy Inspection es. FUNERAL DIRECTOR: Undetermined manner death resulted from: Natural causes Suicide Homicide CHIEF MEDICAL EXAMINER your 4 execute Page MAN ASSISTANT MEDICAL EXAMINER SIGNATURE for 10 DEPUTY MEDICAL EXAMINER Health **EXAMINER'S** director. retained NAME (Type) BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR CREMATOR' LOCATION (City, town or county) 23 c. REMOVAL (Specify) 0 DUNT FUNERAL DIRECTOR ADDRESS 25a. BY REGISTRAR 1966 VR A15ME 3500 4-64 O-ROVE

CERTIFICATE OF DEATH 16972 requires that the deoth certificate be executed within 24 hours after deoth deoth campletely filled in by the funeral tove corban papers. Pages 1 and 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY b. COUNTY Maryland Carroll MARYLAND b. CITY OR TOWN (If autside carparate limits. c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give negrest town)
Rural Union Bridge 3 months Tanevtown ban papers. within 72 hc d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address) 00 Route First Middle 4. DATE emove corban 3. NAME OF Last Manth DECEASED DEATH December 2. Florence Mav Foreman (Type or print) 9. AGE (In years SEX 8. DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthdoy) TC. WIDOWED DIVORCED May 30, 1889 Female White puo 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) during mast af warking life, even if retired) INDUSTRY ottending physician permit. Then please Housework Own home Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME William Moser Elizabeth Wantz 17. INFORMANT Address 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give war or dotes of service) 0 Mrs. Harry Pittinger, R #5. Westminster, Md. No 220-01-6956 cremotion, CAUSE OF DEATH (Enter only one cause per for (a), (b), and (c).) signed by the buriol-tronsit p PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stating the underlying couse by the hospitol or ottending os the TO FUNERAL DIRECTOR: After this certificate has been of Health priar to PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PHYSICIAN: The use CERTIFICATION for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20g. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) 20c. TIME OF INJURY Month, Day, Year Hour o.m. factory, street, office bldg., etc.) Not While at wark at wark should be 21. I certify that (1) (this haspital) attended the deceased fram 9 19 6 6 and that death accurred a 10.15 M, fram causes and an the date stated above saw the deceased alive an 220. SIGNATURE ATTENDING STAFF PHYS. DIRECTOR M.D. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S O HOSPITAL director, po should be f NAME (Type) 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION 23b. DATE THEREOF REMOVAL (Specify) Taneytown, Carroll, Maryland Reformed Cemetery Dec. 5. 1966 247 FUNERAL DIRECTOR

0.0. Fuss & Son, Taneytown, Maryland DATE

2Sq. REC'D BY REGISTRAR

2Sb. REGISTRAR'S SIGNATURE

(County)

(County)

22b. DATE SIGNED

Carroll

e. IS RESIDENCE ON A FARM?

Year

19 66

IF UNDER 24 HRS.

YES

Hours

INTERVAL BETWEEN

WAS AUTOPSY PERFORMED?

YES

1966 that (1) (we) last

NO

(Stote)

(State)

Day

Days

12. CITIZEN OF WHAT

COUNTRY?

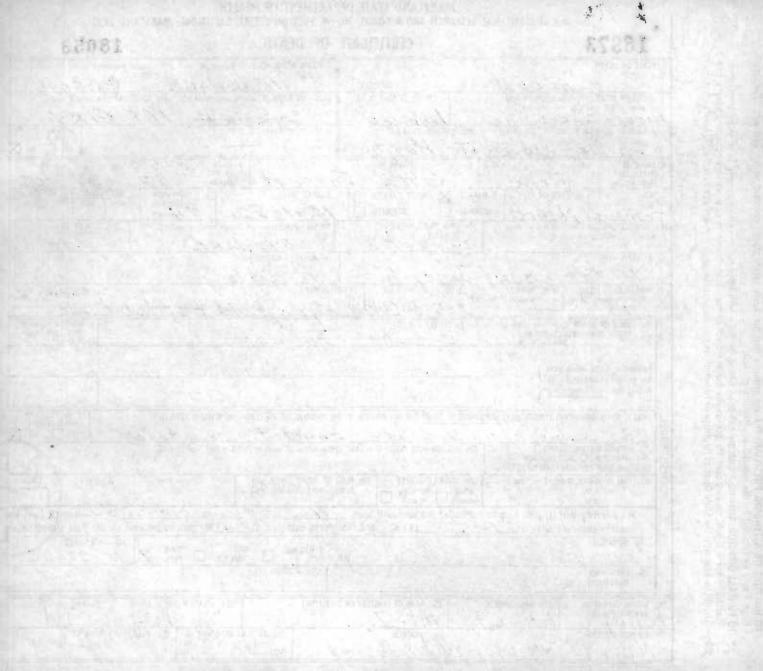
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16973 CERTIFICATE OF DEATH 18053 The law requires that the death certificate be executed within 24 haurs after death attending physician and campletely filled in by the funeral permit. Then please remave carban papers. Pages 1 and ion, or removal, ordin any event, within 72 hours after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY C. ARROLI MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside forporate limits, write RURAL and give nearest tawn) write RURAL and give nearest town) IS RESIDENCE ON A FARM? d. STREET ADDRESS INSTITUTION (If not in hospital, give street address) 12 NO X 3. NAME OF 4. DATE Doy Year DECEASED (Type or print) 5.5 DEATH S. SEX COLOR OR RACE DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED birthdoy) Months Dovs Hours WIDOWED DIVORCED 10g, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service 18. CAUSE OF DEATH (Enter only one couse per line for (o), INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) signed by DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse Page 4 may be retained by the hospital ar attending TO FUNERAL DIRECTOR: After this certificate has been far use as the lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO YES 20g. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter Joture of injury in Port I or Port II of item 1B.) detached f te Dept. af I OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form. (City or town) (Stote) 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED (County) Not While foctory, street, office bldg., etc.) ot work pe 21. I certify that (I) (this hospital) attended the deceased fram 11-25-, 1966, ta 12-31, 1964 that (X (we) last 12-31- 1965, and that death accurred at 2:15 MM, from causes and on the date stated above. saw the deceased alive an_ 22b. DATE SIGNED 22g. SIGNATURE 12-31-66 M.D. PHYS. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) NA director, shauld b 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) Stote) BURIAL, CREMATION, REMOVAL (Splecify) 25b. REGISTRAR'S SIGNATURE 250. REC'D BY REGISTRAR FUNERAL DIRECTOR VR A15 (4) 20 M 1/66



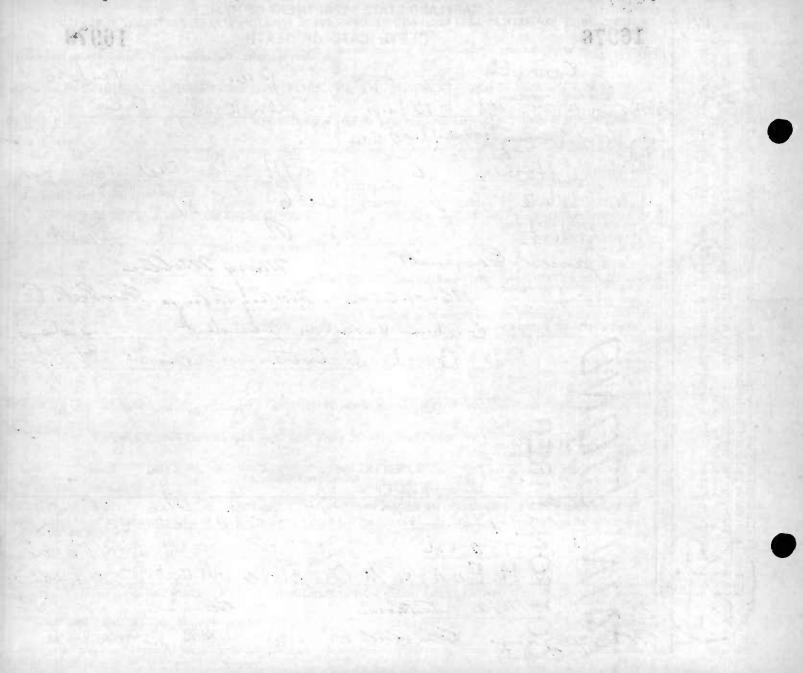
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 16974 requires that the death certificate be executed within 24 haurs after death. death sician and campletely filled in by the funeral please Jemove carban papers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b write RURAL and give neorest town) 35 DAYS FINKSBURG a. NAME OF HOSPITAL OR INSTITUTION (IT not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? CARROLL CO GENTRA YES NO Z 3. NAME OF 4 DATE Month Lost Doy Year DECEASED 19 66 (Type or print) DEATH 9. AGE (In years lost birthdoy) IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH Months Doys Hours MARCH 23, WIDOWED 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) INDUSTRY during most of working life, even if retired) COUNTRY? 13. FATHER'S NAME ar remayal, PITZNO 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT II OCUST AUE. (Yes, no, or unknown) (If yes give wor or dates of service EDWARD J. FROCK 220-18-1917 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
 PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-transit ONSET AND DEATH signed by 1 IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been as the last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION NO the haspital ar for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form. (City or town) (County) (Stote) foctory, street, office bldg., etc.) Not While ot work ot work 21. I certify that (1) (this haspital) attended the deceased fram. Dec 20, , 1966, ta Dec. 23, 1966, that (1) (we) last O HOSPITAL OR ATTENI Page 4 may be retained saw the deceased alive an 2 3, 186, and that death accurred at 5 5 M, fram causes and an the date stated above. 22b. DATE SIGNED 22o. SIGNATURE ATTENDING sher 5, Harshe M.D. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S director, pa DHN S, HARSHEY Sucho NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (Stote) REMOVAL (Specify) FASANT VALIFU ADDRESS 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 1966

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 16975 CI executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) the funeral PLACE OF DEATH a. COUNTY b. COUNTY Carroll Maryland Montgomery MARYLAND physician and completely filled in by the fur en please centave carban papers. Pages 1 oval, and in any event, within 72 hours after c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b Silver Spring Sykesville 24D Rural d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 836 Bonifant Street Springfield State Hospital NO X 3. NAME OF First Middle 4. DATE Year DECEASED 66 John 12 Helvey Fowler (Type ar print) DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED 6 last birthday) 1-2-1890 male white WIDOWED T DIVORCED 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 10a, USUAL OCCUPATION (Give kind af work dane 10b. KIND OF BUSINESS OR that the death certificate be during mast af warking life, even if retired) unemployed USA USA Penna. unknown 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME burial, crematian, or removal, William Fowler Mary--Helvev 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, na, ar unknown) (If yes give war ar dates of service 579-26-9574 Hospital Records unknown INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) signed by the burial-transit p ONSEL AND DEATH PART I. DEATH WAS CAUSED BY: Uremia IMMEDIATE CAUSE (a) DUE TO Nephrosclerosis, chronic Canditians, if any, which gave (b) rise to immediate cause (a). DUE TO stating the underlying cause Page 4 may be retained by the haspital ar attending as the Arteriosclerotic cardiovascular disease vears PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? of far use of Health Chronic brain syndrome associated with arteriosclerosis, cerebrake r this certificate had detached far use 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) director, page 3 shauld be detache shauld be filed with the State Dept. 20c, TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or tawn) (County) (State) While at work factory, street, affice bldg., etc.) O FUNERAL DIRECTOR: After director, page 3 shauld be d 19 66 that (A) (we) last 1966 to 12-8 21. 1 certify that ((this haspital) attended the deceosed from_ _19.66, and that death occurred at 7:30 M, from causes and on the date stated above. sow the deceased alive on 12-8 22b. DATE SIGNED 12-8-66 22a. SIGNATURE ATTENDING M.D. DIRECTOR PHYS. PHYS Springfield State Hospital 22d. ADDRESS 22c. PHYSICIAN'S Klaatsch, M.D. NAME (Type) Sykesville, Maryland 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF (State) 23a. BURIAL CREMATION. REMOVAL (Specify) Dec. 9, 1966 Memorial Park Cemetery St. Louis, Missouri 2Sb. REGISTRAR'S SIGNATURE ADDRESS 2Sa. REC'D BY REGISTRAR FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 סטנו

MARYLAND STATE DEPARTMENT OF HEALTH

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'n.	20 E	1		16976 CERTIFICATE OF DEATH 16973
er death.	e funeral 1 and 2 ter death		1.	PLACE DF DEATH a. COUNTY Carroll 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. COUNTY D. COUNTY
after	in by the fur Pages 1 a nours after d			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)
hours	S		N	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS d. STREET ADDRESS e. IS RESIDENCE
24	tely filled in by ton papers. Page within 72 hours a	90	L	ong View Nursing Home (128N Main
within	wit		3.	NAME OF Erst Middle Lest 4. DATE Month Day Year
× pe	comple ve cart event,		5.	(Type or print) / former L 0-CM/// DEATH Lev /6 1966
executed	and cor		-	SEX 6. CDLOR OR RACE 7. MARRIED NEVER MARRIED 18. DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 HRS. Months Days Hours Min. WIDDWED DIVORCED Oct 6 - Yrs. WIDDWED DIVORCED Oct 6 - Yrs. WIDDWED WIDDWED DIVORCED Oct 6 - WIDDWED WIDDWED DIVORCED Oct 6 - WIDDWED WIDDWED Oct 6 - WIDDWED WIDDWED Oct 6 - WIDDWED WIDDWED Oct 6 - WIDDWED
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certificate	hen phys		13.	FATHER'S NAME Generall 14. MOTHER'S MAIDEN NAME Morry Miller
death cer	the attending I it permit. Then nation, or remov		15. (Ye	WAS DECEASED EVER IN U.S. ARMED FDRCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (If yes give war or dates of service) 176-01-37-22 Win Reg Patrices Here Ref. Po
that the de	the ation		1	18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebra Vascular accident IMMEDIATE CAUSE (a)
es that	hys sign iria uria			331X Conditions, If eny, which (b) Cerebral artemosclerosis Hypers
requires	ding beer the or to			gave rise to immediate cause (a), stating the underlying cause last. DUE TD (c)
The law	att se h	0	CATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NDT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES \(\bigcap \) NO \(\bigcap \)
ICIAN:	hospital or certificate ched for ur pt. of Heali		CERTIFICATION	2Da. ACCIDENT WAS UNDERLYING DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) DR CDNTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
G PHYSICIA	esta De		MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20m. 19 20m. 20m
ATTENDING	OR: Af hould by the Si			21. I certify that (1) this hospital) attended the deceased from 12/4, 1966, to 12/16, 1966, that (t) (we) last saw the deceased alive on 12/16 1966, and that death occurred at 7.20M, from the causes and on the date stated above.
OR	ay be retained by the DIRECTOR: After to the After the State filed with the State			22a. SIGNATURE UN Trown M.D. ATTENDING MED. STAFF 22b. DATE SIGNED / 12/16/66
HOSPITAL	ERAL or, P	1		22c. PHYSICIAN'S NAME (Type) W. H. FOATL M.D 22d. ADDRESS NAM Chester Md 21102
TO HO	To FUN direct		23a	REMOVAL (Specify) 12/19/cb Futherer Glas Rock Po
	R A[5 (4)		24	FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 19 1966 VOLCONTO.
	0M 1/65		<u> </u>	Helieft Date

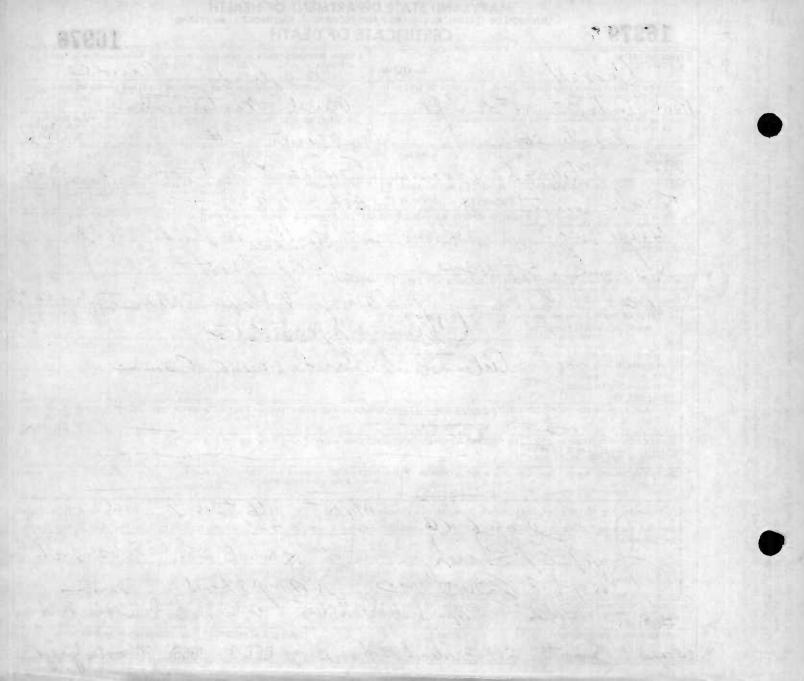


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	the the after		CARROLL - COUNTY MARYLAND MARYLAND CARROLL	
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	fical g ph en p		13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	
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	e it the	a	(Yes, no, or unkown) (If yes give war or dates of service) 219-12-21001 SON-RAYNAND S. GORSUCH WESTNIASTER.	AG.
	the dea n. by the a nsit peri	10	18. CAUSE OF DEATH [Enter only one cause per tine for (a), (b), and (c).]	EEI
	that the ician. ned by the remait it, cramain	-	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Fewlure Shorts	(1
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	e er at		Hour a.m. While Not While p.m. 19 at work at work	
			21. I certify that (I) (this hospital) attended the deceased from cury, 1963 to 15, 1966, that (I) (we) saw the deceased are on the date stated about 1966, and that death occurred at 145 M, from the causes and on the date stated about 1966.	
	retz FCTC 3 sh with		saw the deceased are on the date stated ab 22a. SIGNATURE 22b. DATE SIGNED	JUV
)	AL OR lay be L DIRE page 3		Western persherms. ATTENDING MED. STAFF PHYS. 12-16-66	
	Be Be	1	22c. PHYSICIAN'S W. G-FENN SPEICHER Williamster and	
	Page 4 Page 4 FUNE directo	0	23a. BURIAL, CREMATION, 23b. DATE, THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
	1 P S	a	BURIA - DEC/18/66 BETHESDA CEMETER GIST. MD.	
	VD ALE (4)	18	24. FÜNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC. 19 1000 OCI.	
	VR AI5 (4) 20M 1/65		famo o Saffell for MESTMINSTER 10 MEC 19 1966 golvanley Judge	_

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16978 CERTIFICATE OF DEATH death. requires that the death certificate be executed within 24 hours after death and campletely filled in by the funeral 2. USUAL RESIDENCE (Where deceosed lived, if institution: PLACE OF DEATH Residence before admission) o. COUNTY o. STATE b. COUNTY Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH DE STAY IN 1b c. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Week Sykesville, Md Westminster ban papers. within 72 hc e. IS RESIDENCE ON A FARM? d. NAME OF HDSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS NO FE Carter Road YES T County General Hospita 3. NAME OF Middle 4. DATE First Month Doy Year DECEASED Josephine Gallagher 66 (Type or print) reenfield DEATH Dec IF UNDER 24 HRS. IF UNDER 1 YEAR 5. SEX 9. AGE (In years 6 COLOR OR RATE 7. MARRIED NEVER MARRIED DATE OF BIRTH lost birthdoy) Months Dovs WIDOWED DIVORCED White 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12, CITIZEN OF WHAT COUNTRYSA during most of working life, even if retired) Md. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Ether Wood Joseph Gallagher 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (Yes, no. or unknown) (If yes give wor or dotes of service) Greenfield Sykesville Mr. Dickson 1B. CAUSE OF DEATH (Enter only one couse per line for (s) ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gave rise to immediate couse (a). DUE TO stoting the underlying couse as the O FUNERAL DIRECTOR: After this certificate has been PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? NO for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) 200. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 2De. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Yeor 2Dd. INJURY OCCURRED Not While foctory, street, office bldg., etc.) ot work L . 1900 that (I) (well ast 21_1 certify that (1) (this hospital) attended the deceased fram-10 // and that death accurred at 215 4 M, fram causes and an the date stated above saw the deceased alive and 22b. DATE SIGNED 22a7SIGNATURE STAFF PHYS. DIRECTOR M.D. PHYS. 22d. ADDRESS 22c/ PHYSICIAN'S NAME (Type director, shauld b 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) BURIAL CREMATION. REMOVAL (Specify) 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS Charles VR A15 (4) DATE DEC

Marie Committee of the

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND 16979 CERTIFICATE OF DEATH I directar, filed with 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) PLACE OF DEATH o. COUNTY b. COUNTY MARYLAND mull death. c. CITY OR TOWN of civiside corporate limits, write RURAL and give negrest town) b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 RURAL and give nearest town) D d. STREET ADDRESS IS RESIDENCE d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ON A FARM? YES NO c DATE NAME OF Middle Month Yeor **First** Day Lost DECEASED DEATH (Type or print) 19 SPRA Thin AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 5. SEX 7. MARRIED NEVER MARRIED B. DATE OF BIRTH lost bighdoy) Doys Months Hours Min. DIVORCED WIDOWED D YES 12. CITIZEN OF WHAT COUNTRY? 106. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) during most of working life, even if retired) 13. FATHER'S NAME 14 MOTHER S MAIDEN NAME within physicic emave c WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMAN Address (If yes, give w 0 INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one couse per line for (6), (b) ONSET AND DEATH PART I, DEATH WAS CAUSED BY IMMEDIATE CAUSE (o DUE TO Conditions, if ony, which Pa gove rise to immediate DUE TO couse (o), stoting the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO 200. ACCIDENT WAS UNDERLYING . 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING IL CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (Stote) 20d. INJURY OCCURRED Doy, Year foctory, street, office bldg., etc. Hour o.m. While Not while of work at work p. m 19 66, that (1) (we) lost 21. I certify that (1) (this haspital) attended the deceased from I'v 1966 and that death occurred at A. M. from the couses and on the date stated above. sow the deceased alive on 22b. DATE 220. SIGNATUR ATTENDING PHYS. STAFF PHYS. MED. DIRECTOR M.D. DIRE FUNERAL DIR 22c PHYSICIAN'S 22d. ADDRESS NAME Type 23C NAME OF CEMEPERY OR PREMATOR LOCATION (City, Jower by county) 23g. BURLAL, CREMATION. DATE THEREOF REMOVAL (Speeily) DIERLA 25b. REGISTRAR'S SIGNATURE **ADDRESS** 250. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR'S SIGNATURE 15M 9/59



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 16980 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death o. COUNTY b. COUNTY Baltimore Carroll MARYLAND physician ond completely filled in by the fen please remove-corbon papers. Pages b. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) on papers. Pag within 72 hours Upperco Westminster d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Trenton Road YES X NO Carroll County General Hospital remove corbon p NAME OF DATE First Lost Month Dov Year DECEASED HALE 12 1966 MITCHELL (Type or print) JOSHUA DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED lost birthdoy) Months Doys Hours /11/1891 WIDOWED DIVORCED Male Whi te 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COUNTRY? INDUSTRY Maryland USA Farmer 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME the offending phys Laura Alban Joshua T. Hale IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) ((If yes give wor or dotes of service 215-36-8207 Mrs. Elsie Hale Upperco. Md. no INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the buriol-tronsit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUF TO stoting the underlying couse TO FUNERAL DIRECTOR: After this certificate has been the lost WAS AUTOPS)
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MARYLAND STATE DEPARTMENT OF HEALTH

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PRESTON STREET, BALTIMORE 1, MARYLAND DIVISION OF STATISTICAL RESEARCH AND RECORDS CERTIFICATE OF DEATH the funeral d 2 should ath. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution: Residence before edmission) b. COUNTY e. COUNTY ARROLL ARROLL MARYLAND Pue þ b. CITY OR TOWN (if outside corporete timits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If eatside corporate limits, write RURAL end give neerest town) write RURAL end give neerest town 2. FINKS BURG RT#1 73 FRS.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress) e. IS RESIDENCE ON A FARM? SANDYMOUN completely papers. YES NO 72 3. NAME OF First Middle DATE Dev Month DECEASED OF LEN within PACE (Type or print) DEATH 19 carbon DATE OF BIRTH 9. AGE (In yeers | IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED TEVER MARRIED and last birthday) Months Deys event, WIDOWED DIVORCED physician гетоме 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) CARROLL CO. M. HOUSE - WIFE ease 2 aftending and ā Then 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 1 17. INFORMANT Address SAME (Yes, no, or unkown) | (If yes give we ror detes of service) INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one ceuse per line for (e), (b), end (c). 0 ONS AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) burial-transit **DUE TO** Conditions, if any, which (b) geve rise to immediate cause DUE TO (e), steting the underlying the ceuse last. certificate the hospital PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY 8 O CERTIFICATION PERFORMED? use prior NO X YES Po 20e. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Pert 1 or Pert 1 of item 18.) Health OR CONTRIBUTING TO CAUSE OF DEATH defached (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 2Dc. TIME OF INJURY 2Dd. INJURY OCCURRED I 20e, PLACE OF INJURY (Home, farm, 20f, (City or town) (County) (State) Month, Dey, Yeer ō factory, streat, office bldg., etc.) Whila Not While Hour e.m. DIRECTOR: et work et work p.m 21. I certify that (1) (this hospital) attended the deceased from Allia 196 (4) that (1) (we) las 0 .. 19 6. e, and that death occurred at a left, from the causes and on the date stated above. shoul saw the deceased alive on Decement 22b. DATE SIGNATURE FUNERAL page with th PHYS. DIRECTOR PHYS. HOSPITAL M.D. 22d. ADDRESS 22c. PHYSICIAN'S filed v 23d. LOCATION (City, town or county (Stete) 23Ь. 23c. NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION. D. jg 2 23e. 0 REMOVAL (Specify) 25b. REGISTRAR'S SIGNATURE EUNERAL DIRECTOR'S SIGNATURE VR A15 (4) DATE 20M 5-63

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1 (IVI)	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	16982 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 16979
HEALTH DEPT.	1. PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
	a. COUNTY Carroll Maryland Marvland Carroll Accounty
is necessary, the funeral e 5 may be Department after death.	b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ecessary e funera may by partmen	Westminster Rural-Sykesville at Eldersburg
De 5	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give streat address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
ay tag ag ag ag ag ate	Carroll County General Hospital R.D. 2
and del	3. NAME OF First Middle Last 4. DATE Month Day Year DECEASED OF
f any c 1, 2, ar 1, 2, ar 1, PM3.	(Type or print) William N. Harris DEATH December 16, 1966
ith. If form form form within	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years lest birthday) Hours Hours Min. 1897- 1
death. I Pages ith form form and 2 with form	Male White WIDOWED DIVORCED DIVORCED DIVORCED DIVORCED No. 109. USUAL OCCUPATION (Cive kind of work done) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT
- > × · · · ·	during most of working life, even if retired) INDUSTRY Black Hills
afto ong ss]	Carpenter (retired) South Dakota U.S.A.
hours em 18 ice ald e page nd in a	
fice file	15 WAS DECEASED EVER IN ILS ARMED EXPRESS 16 SOCIAL SECURITY NO. 17 INCORMANT Address
	(Yes, no, or unkown) (If yes give war or dates of service) 12 1); 275
within 2 pencil in miner's 0 permit. I removal,	Yes WW 1 210-14-83/5 Mr. William L. Harris Park, Ma.
executed within ding" in pencil is lical Examiner's Il-transit permit.	PART I. DEATH WAS CAUSED BY:
d be executed "pending" in i Medical Exar burial-transit cremation, or	895. O IMMEDIATE CAUSE (a) CELLULATE (D) HOUTEN
exe Idica Alica al-tr atio	Conditions, If any, which) DUE TO Carhon Monoprell Boisoning
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ould lief	cause (a), stating the underlying cause last.
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EXAMINER: This certificate should be executed the cortificate, writing the word "pending" rould be forwarded to the Chief Medical les. IR: Page 3 should be used as a burial-transignated agent, prior to burial, cremation,	20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part Lor Part II of Item 18.) 20c. EXTERNAL CAUSE WAS CAUSE OF DEATH.
certif riting ded to Id be prior	20a. EXTERNAL CAUSE WAS PRIMARY M or CONTRIBUTING D CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part Lor Part II of them 18.1) Lycur Our bell sin there is a life of them 18.1
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R. This cate, wriforward forward a should agent, p	20c. TIME OF INJURY Month, Day, Year 20d. NJURY & CURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., atc.) 4 the p.m. 12/16 19/6 at work at work at work
AMINER: The certificate, uld be forw s. Page 3 sh	
Pa data	21. I certify that took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion
1 6 2 to 1 5 to 1	death resulted from: Natural causes , Accident , Suicide , Homicide , Ondetermined manner
EDICAL Unte th ge 4 your MRECI	ACTUAL AC
ry MEDIC execute Page I for you IAL DIRE th or its	SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL DEPUTY MEDIC
ase exector.	EXAMINER'S NAME (Type) W. Glenn Speicher Address (street of ty, town ac country Street of the
	23e. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY 23d. LOCATION (City, town or county) (State)
Dagger of to	Burial 12/19/1966 Wesley Freedom Carroll Co., Md.
	24. FUNERAL DIRECTOR ADDRESS 256. REC'D BY REGISTRAR' 25b. RECISTRAR'S SICNATURE
VR A15ME 3500 4-64	C. M. Waltz Box 241 Sykesville, Md. DATE DEC 21 1956 fillandes Judge
3300 4-04	

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1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MA 16383 CERTIFICATE OF DEATH	ARYLAND 981)
24 hours after death. filled in by the funeral sapers. Pages 1 and 2 n 72 hours after death.	PLACE OF DEATH a. COUNTY Carroll MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence as STATE Md. Carroll December 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence as STATE Md. Carroll December 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence as STATE Md. Carroll December 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence as STATE Md. Carroll December 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence as STATE Md. Carroll December 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence as STATE Md. Carroll December 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence as STATE Md. Carroll December 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence as STATE Md. Carroll December 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence as STATE Md. Carroll December 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence as STATE Md. Carroll December 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence as STATE Md. Carroll December 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence as STATE Md. Carroll December 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence as STATE Md. Carroll December 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence as STATE Md. Carroll December 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence as STATE Md. Carroll December 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence as STATE Md. Carroll December 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence as STATE Md. Carroll December 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence as STATE Md. Carroll December 2. USUAL RESIDENCE (Where deceased lived, IT Institution: Residence as STATE Md. Carroll December 2. USUAL RESIDENCE (Where deceased lived, IT Institution: Residence as STATE Md. Carroll December 2. USUAL RESIDENCE (Where deceased lived, I	rroll
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leas	Male White WIDOWEO DIVORCED April 28, 1882 84 yrs. Oa. USUAL OCCUPATION (Give kind of work done uring most of working life, even if retired) Railroad Trackman B & O Railroad Maryland U	FIZEN OF WHAT JUTRY?
or removal,	14. MOTHER'S NAME Valentine Hartman Cornelia Bost	
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending p director, page 3 should be detached for use as the burial-transit permit. Then should be filed with the State Dept. of Health prior to burial, cremation, or removation.	NO 705 09 0197 Mrs. Annie Hartman Sykes 18. CAUSE OF DEATH [Enter only one causa per line for (a), (b), and (c).] PART I. OEATH WAS CAUSEO BY: Coronary occlusion Hartman Sykes	interval Between onset and death sudden one yr.
t. of Health pric		19. WAS AUTOPSY PERFORMED? YES NO
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ld be filed with the St	21. I certify that (I) (this hospital) attended the deceased from Jan 22 , 19 61, to Dec. 23 , 19 60 saw the deceased alive on Dec. 9 19 66, and that death occurred a M, from the causes and on the	e date stated above
-	33. BURIAL CREMATION, 23b. OATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or coun BURIAL 12-26-66 Pine Grove Cemetery Mt. Ajry 24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S LYKSVÜLL, MA. DATEC 28 1966 JOHNSON 1966	Md

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 6984 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death signed by the attending physician and campletely filled in by the funeral burial-transit permit. Then please remove carban papers. Pages 1 and 3 burial cremation, ar removal, and in any eyent, within 72 hours after death I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland a. COUNTY b. COUNTY Carroll MARYLAND Baltimore City b. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn)

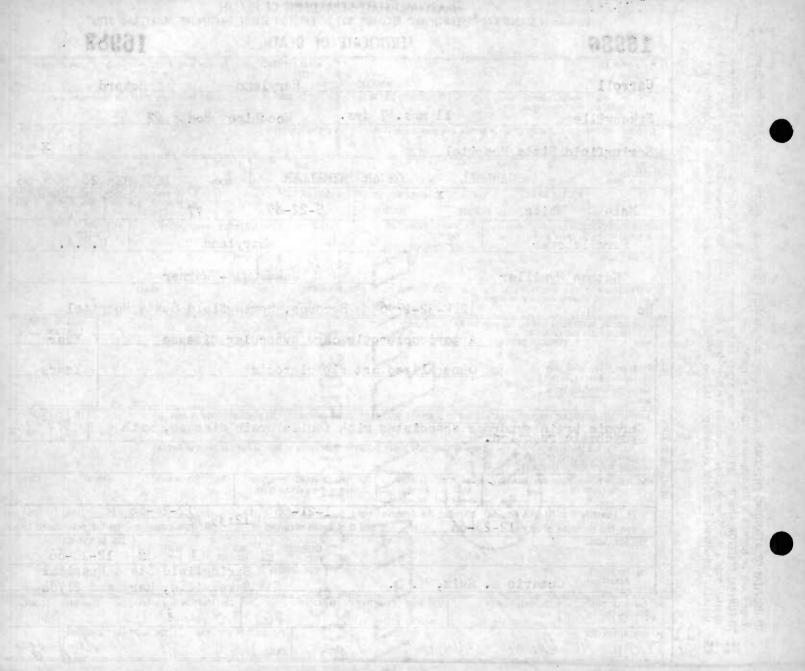
Sykesville c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 24 dys. Bal timore d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 212 E. University Parkway Springfield State Hospital YES \square NO X 3. NAME OF 4. DATE Last Month Day Year DECEASED (Type or print) GERALD WASHINGTON HILL 28 DECEMBER 66 DEATH 19 S. SEX 9. AGE (In years 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 8. DATE OF BIRTH IF UNDER 7. MARRIED NEVER MARRIED last birthdoy) Manths Days Hours Male White 2-22-1898 WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of warking life, even if retired) COUNTRY? INDUSTRY II.S.A Attorney Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME George W. Hill Mary E. Deibel 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no or unknown) (If yes give war or dates of service) 217-38-3330 Records, Springfield State Hospital 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY DAVE AND DEATH Acute pulmonary edema IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gave Arteriosclerotic cardiovascular disease Years rise to immediate cause (a), DUE TO stating the underlying cause Page 4 may be retained by the haspital ar attending as the FUNERAL DIRECTOR: After this certificate has been Years Pulmonary emphysema last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) far use Health NO K YES 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) 20c. TIME OF INJURY Month, Doy, Year (County) (State) Hour a.m. factory, street, office bldg., etc.) Nat While at wark ot work 21. I certify that (1) (this haspital) attended the deceased fram 12-4-66 to12-23-66 _, 19___, that (1) (we) last 12-28-66 19 and that death accurred at 1:30 M. fram causes and an the date stated above. saw the deceased alive on. 220. SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS. K. 12-28-66 director, page 3 shauld be filed v M.D. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S Springfield State Hospital NAME (Type) Octavio A. Ruiz. SykesvIlle, Maryland 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION 23d. LOCATION (City or Town) (Stote) (County) PEMOVAL (Specify) 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR DEC Ochanles 1966 DATE

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12	MARYLAND STATE DEPARTMENT OF HEALTH AUXISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
£ 70£	16385 CERTIFICATE OF DEATH
after death. the funeral ges 1 and 2 after death.	1. PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission
after the figes 1 after after	CARROLL MARYLAND 8. STATE 1) d. D. COUNTY CASTO !!
2=10	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
24 hours filled in by apers. Pagens n 72 hours	RUFAI - FINKS BURG YEARS KUFAI - LOUIS VILLE - FINKS BURG d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE
7 0 = 0	Louisville Road Finksburg-Louisville Rd. YES NO
rted within completely ve carbon I	3. NAME OF DECEASED FOR First Middle Last 4. DATE Month Day Year
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xecu and emo	MALE White WIDOWED DIVORCED April 1/3 /89/ last birthday) Months Days Hours Min.
ficate be er physician a on please ri oval, and in	1Da. USUAL OCCUPATION (Give kind of work done done industry) 12. CITIZEN OF BUSINESS OR during most, of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY.
ate hysic plea	LUMBER MAN LUMBER MARCHANIA U.S. A. 13. FATHER'S NAME 14. MOTHER'S MADEN NAME
death certificate e attending physi permit. Then ple ion, or removal, a	Wm Hutchinson Alverna Noel
eath-certification of removement or removement.	15. WAS DECEASED EVER IN U.S. ARMED FDRCES? 16. SOCIAL SECURITY ND. 17. INFORMANT Address (Yes, no, or, unkown) (If yes give war or dates of service)
E + 1	18. CAUSE DF DEATH [Enter only one cause per ling for (a), (b), and (c).]
hat the deal cian. ed by the transit per , cremation.	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IMMEDIATE CAUSE (a)
requires that the ding physician. been signed by the burial-transit to burial, crema	420.1 IMMEDIATE CAUSE (a)
uires the physical physical physical burial burial burial burial physical p	Conditions, If any, which gave rise to immediate (b) (Light Conditions) (b) (Light Conditions) (b) (Light Conditions) (b) (Light Conditions) (c)
e law requires that the attending physician has been signed been as the burial tranth prior to burial, cre	cause (a), stating the underlying cause last. (c) Comparison (II) 15 4
N: The law rectal or attending title or attending for use as the for use at the fealth prior to the second or the	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH ON NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUX DPSY PERFORMED?
t: Th al or ficat for u Heal	S YES ND ₹
PHYSICIAN: the hospital this certific detached for e Dept. of Ho	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY DCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
PHYS the h this detac e Dep	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) Hour a.m.
NG by ffter be State	
ATTENDING retained by CTOR: After should be vith the Stat	21. I certify that (I) (this hospital) attended the deceased from the deceased from the deceased alive on 1965, and that death occurred a 221M, from the causes and on the date stated above
r etr r rets ECTG 3 sh with	22a. 8 GMATURE 22b. DATE SIGNED
L OR ay be DIR filed	M.D. ATTENDING MED. STAFF DIRECTOR PHYS. DIRECTOR PHYS.
TO HOSPITAL OR ATTENDING PHYSICIAN: The law Page 4 may be retained by the hospital or attento FUNERAL DIRECTOR. After this certificate as director, page 3 should be detached for use as should be filed with the State Dept. of Health priores.	NAME (Type) R. V. HOUCK, JR. 22d. ADDRESS SYKES VILLE, WILL.
Page O FU dire show	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
0	24. FUNERAL DIRECTOR ADDRESS A SECOND TREGISTRAR 25b. REGISTRAR'S SIGNATURE
VR AI5 (4)	Harry W. Haight Sykisville, Md. DATE JAN 1 1967 relieves and
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16986 CERTIFICATE OF DEATH executed within 24 hours after deoth. attending physician and completely filled in by the funeral permit. Then please 1 and 2 and 2 on ar removal, and in ony event, within 72 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) Carrol1 o. STATE b. COUNTY MARYLAND Maryland Howard b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest tawn) 11 mos. 7 dvs. Woodbine Route #2 Sykesville d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? YES X NO Springfield State Hospital NAME OF 4 DATE Lost Day Year DECEASED (Type or print) CARROLL OSCAR HYMILLER 28 DECEMBER 66 DEATH 19 IF UNDER 1 YEAR IF UNDER 24 HRS. 9. AGE (In years S. SEX 8. DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED birthday) Months Dovs Hours 5-22-89 White Male WIDOWED 10o. USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, ar foreign country) requires that the death certificate be during mast of working life, even if retired) INDUSTRY FARMING Maryland Farm laborer 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Nathan Hymiller - Warner 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, ar unknown) (If yes give war or dates of service) 212-32-1796 Records, Springfield State Hospital INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line far (a), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: signed by the burial-transit p ONSET AND DEATH Arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (a) DUE TO Canditians, if any, which gave Generalized arteriosclerosis Years rise to immediate cause (a), DUE TO stoting the underlying couse as the TO FUNERAL DIRECTOR: After this certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? Chronic brain syndrome associated with senile brain disease, with psychotic reaction. NO X for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) (Stote) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) Hour a.m. factory, street, office bldg., etc.) Nat While at wark at wark 2:35to 12-28-66, 19__, that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased fram___ 1-21-66 O HOSPITAL OR ATTEND Poge 4 moy be retoined pluods saw the deceased alive an 12-28-66 19 and that death accurred at 22a. SIGNATURE 22b. DATE SIGNED **ATTENDING** STAFF PHYS. 1 12-28-66 DIRECTOR M.D. PHYS. Springfield State Hospital 22d. ADDRESS 22c. PHYSICIAN'S director, por NAME (Type) Octavio A. Ruiz. M. D. Sykesville, Maryland 2178h 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) 23o. BURIAL, CREMATION REMOVAL (Specify) UKE.SVI 25g. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR DATE



MARYLAND STATE DEPARTMENT OF HEALTH

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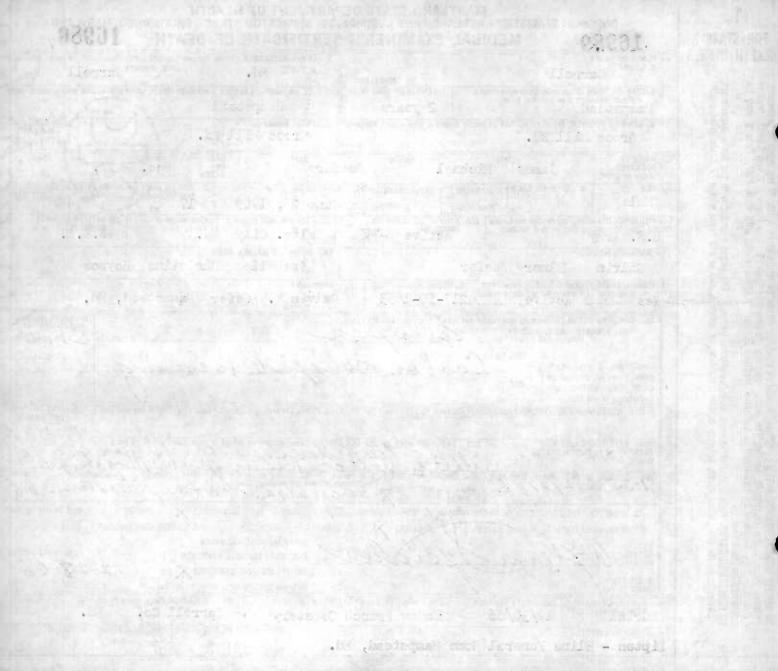
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16988 CERTIFICATE OF DEATH death. The low requires that the death certificate be executed within 24 hours after death. puo 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) physician and completely filled in by the funeral en please remove corbon popers. Pages I and o. COUNTY b. COUNTY MARYLAND c. LENGTH OF STAY IN 16 CITY OR TOWN (If outside corporate limits c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) haurs write RURAL and give nearest town) oon popers. within 72 ho d. STREET ADDRESS IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) YES NOTE 3. NAME OF Middle 4. DATE Month First Lost Doy Year DECEASED 196 (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX DATE OF BIRTH AGE (In years 6 COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthdoy) Months Hours WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 100 USUAL OCCUPATION (Give kind of work done COUNTRY? during most of working life, even if retired), INDUSTRY E-5 13. FATHER'S NAME TAIMMIA MOTHER'S MAIDEN NAM 17. INFORMANT 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dates of service) 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN buriol-transit PART I. DEATH WAS CAUSED BY: AND DEATH IMMEDIATE CAUSE (o) signed by DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse os the be retained by the hospital or attending O FUNERAL DIRECTOR: After this certificate has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) detoched for use te Dept. of Health NO YES [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year Hour o.m. Not While foctory, street, office bldg., etc.) of work ot work should be 6, 1966, that (I) (we) last 21. I certify that (1) (this haspital) attended the deceased fram 1966 ta ond that death occurred at M. from causes and on the date stated above saw the deceased glive on. 22b. DATE SIGNED 22o. SIGNATURE ATTENDING director, poge 3 should be filed v M.D. DIRECTOR PHYS. PHYS. 22d. ANDRESS PHYSICIAN'S 22c. NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) 23b. DATE THEREOF (County) (Stote) 23o. BURIAL CREMATION REMOVAL (Specify) CARROLL 24 FUNERAL DIRECTOR 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE, ADDRESS: VR A15 (4) 20 M 1/66 liances DATE

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1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1_MARYLAND
FOR STATE	16989 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 16986
HEALTH DEPT.	1. PLACE OF DEATH a. COUNTY Carroll AMARYLAND 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) b. COUNTY Carroll MARYLAND
f any delay is necessary, 2, and 3 to the funeral PMI3. Page 5 may be the state Department, in 72 hours after death.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead c. LENGTH OF STAY IN 1b LENGTH OF STAY IN 1b A years Hampstead
delay is ned 3 to the Page 5 State Del	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Gross Mill Rd. d. STREET ADDRESS ON A FARM? YES \(\) NO \(\)
any dell 2, and PM3. the St	3. NAME OF DECEASED (Type or print) James Michael Keefer Last V. DATE Month Dec. 27, 19
	5. SEX Married Never Married 18. Date of Birth Male Wildowed Divorced June 20, 1949 S. Date of Birth June
after death. I S. Give Pages long with form les 1 and 2 wi any event with	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY ACTIVE Army 11. BIRTHPLACE (State or foreign country) Balto. City Md.
4 hours after 18. Gibfrice along File pages 1 and in any	13. FATHER'S NAME Calvin Elmer Keefer Isabelle Christine Haynes
250	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes, ulva war or dates of service) 217-50-1853 Calvin E. Keefer Hampstead, Md.
EXAMINER: This certificate should be executed within e certificate, writing the word "pending" in pencil in hould be forwarded to the Chief Medical Examiner's lies. OR: Page 3 should be used as a burial-transit permit. signated agent, prior to burial, cremation, or removal	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).], PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which (b) Carbon Monafish Poesoning
ate should be the word "pe the Chief Me sed as a buri burial, crem	cause (a), stating the underlying cause last. (c)
s certificat writing the rded to th uld be use uld be use	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO YES NO CAUSE OF DEATH. 19. WAS AUTOPSY PERFORMED? YES NO YES NO CAUSE OF DEATH.
AINER: This tifficate, wr l be forward age 3 shoul ted agent, I	20c. TIME OF INJURY Month, Day, Year 20d. INJURY GEOGRAED 20e. PLACE OF INJURY (Home, farm, Mr. (City or town) (County) (State) Joseph a.m. 2 27 66 While at work at
当年の十年号	21. I certify that I took charge of the remains described above, held a Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural Causes , Accident , Suicide , Homicide , Undetermined manner .
S S S S S	ACTUAL SIGNATUR Personal Personal M.D. ASSISTANT MEDICAL EXAMINER 22. DATE SIGNED DEPUTY MEDICAL EXAMINER 12-78-66
	EXAMINER'S NAME (Type) Address (Street, city, town, or county) 23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
TO DEPU please director retaine TO FUNE	Burial (Specify) 12/30/66 Meadow Branch Cemetery Carroll Co. Md.
VR A15ME 3500 4-64	24. FUNERAL DIRECTOR ADDRESS Tipton - Eline Funeral Home Hampstead, Md. 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE JAN 3 1967 Policy Judge.
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH でいる hours after death. funera and death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY the figes 1 after Carrol] MARYLAND b. CITY OR TOWN (if outside corporate limits. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b filled in by t papers. Page iin 72 hours a write RURAL and give nearest town) Sykesville Baltimore City d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? within Springfield State Hospital Crest Heights Road YES NO X completely i NAME DE First Middle Last DATE Month DECEASED (Type or print) FANNTE: COHEN 1966 KERMISCH DEC DEATH 16 and con 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH AGE (In years LIF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Months White Hours WIDOWED DIVORCED unknown 10a. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT gase, and in death certificate be during most of working life, even if retired) INDUSTRY COUNTRY? housewife U.S.A. Russia 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending ph rmit. Then removal R Joseph Cohen Miriam 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address Sykesville, Md. (Yes, no, or unkown) (If yes give war or dates of service) n signed by the att burial-transit permi burial, cremation, o Records of Springfield State Hospital, no 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c),] INTERVAL BETWEEN OR ATTENDING PHYSICIAN: The law requires that the be retained by the hospital or attending physician. ONSET AND DEATH PART I. DEATH WAS CAUSED BY: DUE TO certificate has been significate has as the burian pt. of Health prior to burian Conditions, If any, which (b) gave rise to immediate DUE TO cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? NO W Chronic brain syndrome, cerebral arteriosclerosis with psychotic YES 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State) det (County) factory, street, office bldg., etc.) Hour a.m. After Not While at work be at work should ith the S 11-13-66 _ to 121 16 21. I certify that (I) (this hospital) attended the deceased from . 19 19 66. that (1) (we) last DIRECTOR: age 3 should lied with the 19 66 and that death occurred at 150 P.M. from the causes and on the date stated above saw the deceased alive on 12-16 22a. SIGNATURE 22b. DATE SIGNED director, page should be filed v ATTENDING Page 4 may b PHYS. DIRECTOR PHYS. PHYSICIAN'S 22d. ADDRESS NAME (Type) Paul G. Ensor, M.D Sykesville, Maryland BURIAL, CREMATION, NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) 2 REMOVAL (Specify) BURIAL PUMERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE VR A15 (4) 1/65

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Paul C. Sugar, S. J.

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534.T the real water of the stand that the water TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cárbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

	DIVISIO	N OF STATISTIC		ARCH AND RECO	RDS	PARTMENT OF , 301 W. PRESTOR			E 1, MAR	YLAND
	16991	Т-	tome 1	CERTIFIC	AT,	E OF DEATH	mh		1698	8
1.	PLACE OF DEATH a. COUNTY Carro			MARYLA	ND	2. USUAL RESIDENCE a. STATE Maryl		eceased lived, If institution b. COUNTY Carr		ence before admission)
	b. CITY OR TOW write RURAL Syke sy	N (if outside corpora and give nearest tov rille	te limits, vn)	c. LENGTH OF STAY I		c. CITY OR TOWN (If o	outside co	rporate limits, write		give nearest town)
(PITAL OR INSTITUTION W Nursing		ospital, give street add	ress)	d. STREET ADDRESS Route				e. IS RESIDENCE ON A FARM? YES NO
3.	NAME OF DECEASED (Type or print)		rst	Middle D.	/ Kl	Last ingelhofer	4. DATE	Month H December	23	1966
-	sex Female	6. COLOR OR RACE White	7. MARRIED WIDOWED			Feb. 28, 188		AGE (In years IF ias birthday)	UNDER 1 YE	AR IF UNDER 24 HRS
lOa	Ing most of working Never	ION (Give kind of working life, even if retire worked	done 10b. K	IND OF BUSINESS OR NDUSTRY		11. BIRTHPLACE (CON	unty & Stat	7	12. CITIZI COUNT	EN OF WHAT TRY? USA
13.	FATHER'S NAM	E				14. MOTHER'S MAIDE	EN NAME			
	Charles	W.	Klin	ngelhofer		Christina	a			
15	. WAS DECEASED E	VER IN U.S. ARMED FO	RCFS? 16.	SOCIAL SECURITY NO.	17.	INFORMANT	-	Address		
(Ye	es, no, or unkown)	(If yes give war or dates o	of service)		Gno	and View Nur	eine i	Home Pager	do	
-	18 CAUSE OF	DEATH FERTOR ORIV OR	o cauco por l	ine for (a), (b), and (c).		and them was	orns.	HOMB RECOT		ITERVAL BETWEEN
		ATH WAS CAUSED BY IMMEDIATE CAUSE	: H			RDIOVASCULAR	DISE	ASE		20+yrs.
	Conditions, If		(b) G	ENERAL ARTER	ROS	CLEROSIS				20+yrs.
N	cause (a), st	e last.	(c) P.			NAL OBSTRUCT		ORIGIN UNK	NOWN	2+yrs.
FICATIO						TED TO THE TERMINAL DI				9. WAS AUTOPSY PERFORMED? YES NO
CERTIF	20a. ACCIDENT OR CONTRIBUTI (IF EITHER, NOT	WAS UNDERLYING DEAD TO CAUSE OF DEAD TO MEDICAL EXAMI	TH NER)	DESCRIBE HOW INJURY	occu	RRED. (Enter nature of	Injury in I	Part I or Part II of I	tem 18.)	
MEDICAL	20c. TIME OF I Hour a.n p.n		Year 20d. I While at worl	Not While	facto	CE OF INJURY (Home, far ry, street, office bidg., etc	rm, 20f.	(City or town)	(County)	(State)
	21. I certify	y that (I) (this best ceased/alive on 23	pital) attend /Dec/66	ed the deceased from		7/Sept/66 , 19 death occurred at 8				
	22a. SIGNATUR	E Attal	vant.		M.D	. PHYS. D	MED. DIRECTOR	STAFF	22b. DATE	SIGNED
	22c. PHYSICIA NAME (Ty	rpe)	awson.	Jr. M. D.		RD #2, Syl	kesvi	lle, Maryl	and 2	21784
232	REMOVAL (Spe	ATION, 23b. DATE (12/24)	THEREOF /19 6 6	23c. NAME OF CEM		k Cemetery	Ba		Md.	
24		CTOR	-	ADDRESS	11	O, has 25a. REC	D BY REG	ISTRAR 25b. REGI	ISTRAR'S SI	GNATURE

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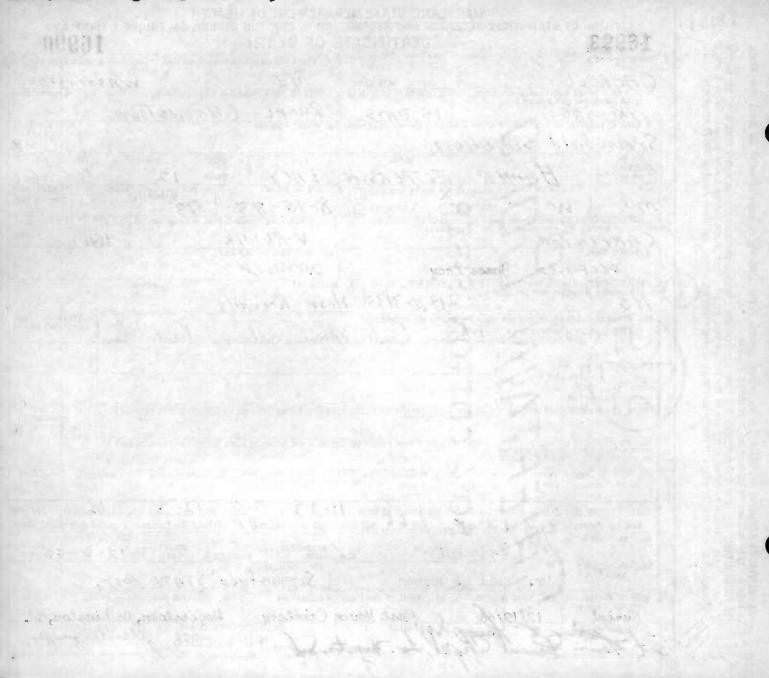
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	1(M)		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARY 16992 CERTIFICATE OF DEATH	YLAND
r death.	funeral 1 and 2 er death.	1,	PLACE OF DEATH a. COUNTY b. COUNTY c. STATE 2. USUAL RESIDENCE (Where deceased lived, If institution: Residen a. COUNTY b. COUNTY	ce before admissio
hours after	in by the 1 Pages 1 iours after	K	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Waryland Carrol MARYLAND Maryland C. CITY OR TOWN-lif outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN-lif outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN-lif outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN-lif outside corporate limits, write RURAL and give nearest town)	Olo 1
24	papers. thin 72 h	S	pring field State Hospital Ruval	e. IS RESIDENCE ON A FARM? YES NO
executed within	and completely filled in by th remove carbon papers. Pages I any event, within 72 hours aft	5,	OECEASED (Type or print) George Washington Knouse, Sr DEATH 12 9	1966
		10:	Male-White WIDOWED DIVORGED 2-18-84 Sast birthday) Months Days B. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11b. BIRTHPLACE (County & State, or foreign country) 12c. CITIZE	Hours Min
certificate be	physician ar please wal, and i	S	ring most of working life, even if retired) SINDUSTRY awm. I habover Sawwill Pennylvania Perry Co. COUNTI BANGER'S NAME 14. MOTHER'S MAIDEN NAME	(A)
ith certif	attending rmit. Then n, or remov		5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (es, no, or unkown) (If yes give war or dates of service) 218-54-4480 Mrs. Nancy Knouse Finks bur	(arec.)
the death	the it pe		18CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).1 PART I. DEATH WAS CAUSED BY:	PERVAL BETWEEN
res that the	signer signer urial-t urial,		4501 Conditions, if any, which) DUE TO Branch of neumanica	longs
law requires	ttending has been as the b prior to b	N	gave rise to immediate cause (a), stating the underlying cause last. DUE TO CO CO CO CO CO CO CO CO CO	e ouls
The	ificate for use Health	CERTIFICATION	20a. ACCIDENT WAS UNDERLYING 1 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)	PERFORMED?
PHYSICIAN:	the nospir this cert detached e Dept. of		20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County)	(State)
2	After After Id be e Stat	MEDICAL	21. I certify that (I) (this hospital) attended the deceased from 7-1-, 1957, to 12-9-, 1966,	that (V) (we) la
-	DIRECTOR: A DIRECTOR: A ge 3 should led with the		saw the deceased alive on 2 - 196, and that death occurred at PM, from the causes and on the deceased alive on 2 - 22a. SIGNATURE Such a Office MED. STAFF DIRECTOR DIRECTOR PHYS.	
PITAL	RAL RAL r, pa		22c. PHYSICIAN'S NAME (Type) Suha OZGUN 22d. ADDRESS Springfield State Hospia	tal.
TO HC	To FUNE director should I		a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) Burial 12/12/66 Evergreen Mem. Gardens Finksburg 4. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNARY.	(State) Md.
VF	AI5 (4)		Tipton-Eline Fun. Home, Hampstead, Md. DATE DEC 1 3 1966 Icharle	es Judge

VR AI5 (4) 20M 1/65

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1(Ivi)	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET	
, 2ª i	16993 CERTIFICATE OF DEATH	16990
after death. the funeral ges 1 and 2 after death.	PLACE OF DEATH COUNTY STATE	ased lived, If Institution: Residence before admission) b. COUNTY
the f	(ABBOLL MARYLAND Md.	WASHINGTON
completely filled in by the five carbon papers. Pages 1 event, within 72 hours after	write RURAL and give nearest town)	prate limits, write RURAL and give nearest town)
val, and in any event, within 72 hou	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	GERS TOWN.
12	SPRINGfield STATE HOSP.	ON A FARM? YES NO
	3. NAME DF DECEASED HOMER TEFFERSON LACY DEATH DEATH	Month Day Year
		AGE (In years IFUNDER 1 YEAR IFUNDER 24 HRS.
	m WIDOWED DIVORCED 8-15-88	Jast birthday) Months Days Hours Min.
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY	COUNTRY?
	CARPS NTER VIRGINIA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	USA
	DECEMSED James Lacy DECEMSED	
G	5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY ND. 17. INFORMANT	Address
	NO 219-20-3135 HOSP-ROCORDS	
	18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY:	INTERVAL BETWEEN DNSET AND DEATH
	1199 IMMEDIATE CAUSE (a) Moure Colollo Vigitula Callens se	leholes des
37	Conditions, If any, which (b)	
	gave rise to immediate cause (a), stating the DUE TO	
	Underlying cause last.) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND	ITION GIVEN IN PART 1(a) 119. WAS AUTOPSY
0	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Par OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NDTIFY MEDICAL EXAMINER)	PERFORMED? YES ND
	20a. ACCIDENT WAS UNDERLYING DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Par DR CONTRIBUTING DEACH CAUSE OF DEATH (IF EITHER, NDTIFY MEDICAL EXAMINER)	t I or Part II of Item 18.)
		lty or town) (County) (State)
	20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2Df. (Compared to the compared to the c	try of towny (country) (country)
	21. I certify that (I) (this hospital) attended the deceased from 1/-23 . 1966 to 1	2-8, 1966, that (1) (we) last
	saw the deceased alive on 12-8 1966, and that death occurred at 8 P. M, from 22a. SIGNATURE	n the causes and on the date stated above.
	M.D. ATTENDING MED. DIRECTOR	
	22c. PHYSICIAN'S 22d. ADDRESS	TATE HOSP.
/	Dr. nueti E. connor Sering field 3	ATION (City, town or county) (State)
	REMOVAL (Specify)	
Sa	24. FUNERAL DIRECTOR 1 25a. REC'D BY REGIST	erstown Washington Md. 1881 256. REGISTRAR'S SIGNATURE 1966 Histories Junge
3	Best Haven Guilla Chapel, In Hugertonny DATEC 12 1	300



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 16994 requires that the death certificate be executed within 24 haurs after death. and campletely filled in by the funeral remave carban papers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) 6. ARRE! o. COUNTY b. COUNTY MARYLAND c LENGTH OF STAY IN 1h b. CITY OR TOWN (If gutside carparote limits. c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest tawn) write RURAL and give negrest town) EST MINS TER d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 16 Kemper Ave. YES T NO 3. NAME OF Middle 4. DATE Last Month Day Year DECEASED Martin December 21 19 66 HENRY John (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S. SFX 6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years 7. MARRIFD NEVER MARRIED last birthday) Months Hours Maba White WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT COUNTRY? during mast af warking life, even if retired) INDUSTRY CARROLL CO.MO RURAL MAIL CAR 14. MOTHER'S MAIDEN NAME ELEANOR HOUCK the attending 16. SOCIAL SECURITY NO 17. INFORMANT SAME MRS. JOHN H. MAR INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE (AUSE (a) Cerebral Arteriosclerosis signed by 5 mo DUE TO General Arteriosclerosis 5 years Canditians, if any, which gove rise ta immediate cause (a), DUF TO stating the underlying cause has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? NO TO FUNERAL DIRECTOR: After this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 1B.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or tawn) (Caunty) (Stote) Nat While factory, street, affice bldg., etc.) at wark at wark 21. I certify that (1) (this haspital) attended the deceased fram_Cusy 1900 . ta 1966, and that death occurred at 600 M, fram causes and an the date stated above saw the deceased olive an 12-21 22a. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. DIRECTOR PHYS. PHYS. 22d. ADDRESS PHYSICIAN'S TO HOSPITAL Maurice C. Porterfield director, po shauld be f NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF (County) (State) 23o. BURIAL, CREMATION, REMOVAL (Specify) 250 REC'D BY REGISTRAR DATE 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR

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ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after be retained by the hospital or attending physician.

粉	16995	CERTIFICA	IE OF DEATH		10332
-	1. PLACE OF DEATH o. COUNTY				institution: Residence before admission
ı	Carroll	MARYLAND	a. STATE Mary	land b. COUN	" Carroll
ı	b. CITY OR TOWN (if outside corporate limits, write RURAL end give neerest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (IF	outsida corporate limits, write	RURAL end give neerest town)
ı	Middleburg	5 months	Tane	ytown	06.1
ı	d. NAME OF HOSPITAL OR INSTITUTION (if not in ho	ospital, give street address)	d. STREET ADDRESS		IS RESIDENCE ON A FARM
ı	Brookfield Manor Nursin	ng Home	East	Baltimore St	reet YES NO X
1	3. NAME OF First DECEASED	Middle	Lesi	4. DATE Month	Day Year
	(Type or print) Edward	Harison	Miller	DEATH Decemb	er 19 1966
ı	5. SEX 6. COLOR OR RACE 7. MARRI	ED NEVER MARRIED B	, DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS
ı	Male White whow	ED X DIVORCED 1	March 18, 187	5 91 yrs.	Months Days Hours Min.
	10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	KIND OF BUSINESS OR INDUSTR	Y 11. BIRTHPLACE (County	& State, or foreign country)	12. CITIZEN OF WHAT COUNTE
ı	Farmer	arming	Maryland		U.S.A.
ı	13. FATHER'S NAME		14. MOTHER'S MAIDEN N	AME	
	William H. Miller		Susar	n Foreman	
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 (Yes, no, or unknown) (Ifyesgive werordetes of service)	. SOCIAL SECURITY NO. 17. 1	INFORMANT	Address	
	no (if yes give were reference service)	none Cha	arles R. Mille	er Tan	eytown, Maryland
1	18. CAUSE OF DEATH [Enter only ona causa per	line for (a), (b), and (c).]	0'		INTERVAL BETWEEN
	gave rise to immediate cause (a), stating the underlying cause lest. (b) DUE TO				
H	PART II. OTHER SIGNIFICANT CONDITIONS CO	NTRIBUTING TO DEATH BUT NO	OT RELATED TO THE TERMINA	AL DISEASE CONDITION GIV	YEN IN PART 1(a) 19. WAS AUTOPS PERFORMSQ?
	& atheroschot		Voscular d		YES NO
	200. ACCIDENT WAS UNDERLYING A 2DB. DE OR CONTRIBUTING A CAUSE OF DEATH OF THE CONTRIBUTING A CAUSE OF DEATH OF THE CONTRIBUTION OF THE CONTRIBUTI	SCRIBE HOW INJURY OCCURED). (Enter nature of injury in Pa	rt I or Pert II of item 18.)	
	20c. TIME OF INJURY Month, Day, Year 20d Whi Hour e.m. 19 at we	leNot While fec	ACE OF INJURY (Home, farm, lory, streat, office bldg., atc.)	20f. (City or town)	(County) (State)
	21. I certify that (I) (this hospital) atte	nded the deceased from.			(e, 19, that (I) (we) I
	saw the deceased alive on	19 and that	death occured at 2.2	M, from the causes	and on the date stated abo
	220. SIGNATURE A Care of	N	I.D. PHYS. DII	ED. STAFF RECTOR PHYS.	12 9 TO SIGN
1	22c. PHYSICAN'S NAME (Type) J. H. Caricof	Ce, M.D.	22d. ADDRESS Union	n Bridge, Mar	yland
	238. BURIAL, CREMATION, 236. DATE THEREOF	23c. NAME OF CEMETERY	OR CREMATORY	23d. LOCATION (City, to	wn or county) (State)
	REMOVAL (Specify) Burial 12/21/66	Lutheran Cem	etery	Taneytown	Maryland
	24 FUNERAL DIRECTOR'S SIGNATURE	16- ADDRESS		D BY REGISTRAR 256. RE	
0	C.O. Fuss & Son, John M. S	Total Tona Tona	Md DATE	JEC 21 1966	Tollares Judge
1	LATOR THES OF DOIL "AOUN W. P	KILLES . I ANEVTO	Nn . Ma		

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

March 187 1873 Charles and the transfer of the same and the contract of the c the state of the s make the second of the man Union Fridge, Mary Lord Lalitation of the Company of the Com 10.00 Fitte C Jon State S. States, Congressed Line Co. 5177

.1 (N	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	16996 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 16993
HEALTH DEPT.	1. PLACE DF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE b, COUNTY
7 8 a.c.	Carroll Maryland Baltimore City
is riecessary, o the funeral e 5 may be Department after death.	write RURAL end give nearest town)
the f 5 m 5 m	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE
delay is riecessary, and 3 to the funeral Page 5 may be State Department hours after death.	Springfield State Hospital 3648 Ash Street VES NO X
<u> </u>	3. NAME DF First Middle Last 4. DATE Month Day Year DECEASED OF OF
2:3 =>	(Type or print) GEORGE EDWARD MONTGOMERY DEATH December 13 19 66
Pages 1, 2 th form P d 2 with nt within	Male Work Days Hours Min.
dea ith ith ond ent	1Da. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?
after ding wild wild wild wild wild wild wild wild	Laborer Maryland U.S.A.
N 00-3	13. FATHER'S NAME 14. MÖTHER'S MAIOEN NAME
24 hour litem 1 Office a	William H. Montgomery Annie E. Fogler 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address
s (in al,	(Yes, no, or unkown) (If yes give war or dates of service) No 215-07-6563 Records, Springfield State Hospital
uted within 2 "in pencil in Examiner's 0 nsit permit. I	18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).]
Exal Sit or	PART I, DEATH WAS CAUSED BY: ON IMMEDIATE CAUSE (a) Confidence of the confidence of
d be execui "pending". Medical E burial-trans	Conditions, If any, which) DUE TO STACKED (C. TIAN - Pre / Conditions)
d be e "pend Medial burial	gave rise to immediate cause (a), stating the DUE TO
hould ord thief s a s a	underlying cause last. (c)
Tcate sho the worn the Chi the Chi used as to burial	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMEO? YES 19. WAS AUTOPSY PERFORMEO? YES NO 1.
his certificate should writing the word "yarded to the Chief Neudle be used as a buth, prior to burial, cre	2Da. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter neture of Letury in Part I or Part II of Item 18.)
s cen writin rrded nuld h	
EXAMINER: This certificate should be certificate, writing the word "pen nould be forwarded to the Chief Med les. R: Page 3 should be used as a buria signated agent, prior to burial, cremasignated agent,	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 22d. PLACE OF INJURY (Home, farm, Springfield State Hospital Bacthroom Springfield State Hospital Bacthroom Sykesville, Carroll, Md.
CAMINER: The certificate, uld be forw s. Page 3 sh	
L EXAMI he certi should I files. TOR: Pa	21. I certify that 1 took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes Accident, Suicide, Homicide, Undetermined manner
- 4 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5	CHIEF MEDICAL EXAMINER
MEDICAI Xecute the Page 4 of for your IL DIRECT or its d	ACTUAL SIGNATURE CONTROL SIGNATURE ACTUAL SIGNATURE ACTUA
exe exe for for the lith of th	EXAMINER'S NAME (Type) W. Glenn Speicher, M.D. DEPUTY MEDICAL EXAMINER Address (Street North, town, industry turnsless for the control of th
D DEPUTY MEDICA please execute t director. Page 4 retained for your O FUNERAL DIREC of Health or its d	23a. BURIAL, CREMATION, 23b. DATE THEREOF, 23c. NAME OF CEMETERY OR-CREMATORY 23d. LOCATION (City, town or county) REMOVAL (Specify) 12 1 (9 16 6 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
Dage Do	Januar 14/1490 mo quaring.
VR A15ME	DEC 19 1966 Victorian Judge
35DD 4-64	Hargho dune al Home Dykesville, Mile.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16997 CERTIFICATE OF DEATH law requires that the death certificate be executed within 24 hours after death death physician and campletely filled in by the funeral en please remave carban papers. Pages 1 and 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b_COUNTY Maryland Carroll MARYLAND b. CITY OR TOWN (If autside carparate limits, c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b write RURAL and give negrest tawn) Life Sykesville kesville d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? within 72 R. D. 3 R.D. YES NO 3. NAME OF Middle 4. DATE First Lost Month Doy Year DECEASED Albert D. Nickoles 14,1966 December (Type ar print) DEATH 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED last birthday) Manths Days White 10,1893 Male Dec. WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of warking life, even if retired) INDUSTRY COUNTRY? Carroll Co., Md. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME signed by the attenting phy burial-transit permit. Then Emma T. Heiser Henry Nickoles SameAddress 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, na, or unknown) (If yes give war ar dates of service) Mrs. Katherine A. Nickoles INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Canditians, if any, which gave rise to immediate cause (a), DUE TO stoting the underlying cause Page 4 may be retained by the haspital ar attending this certificate has been last. 19. WAS AUTOPS)
PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO To 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II af item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Haur a.m. factory, street, office bldg., etc.) O FUNERAL DIRECTOR: After 21. I certify that (1) (this hospital) attended the deceased fram____ , 1966, ta 12-14 . 1966, that (I) (we) last now 19 66, and that death accurred at 1020 PM, fram causes and an the date stated above. saw the deceased alive an 12-14 22a, SIGNATURE 22b. DATE SIGNED **ATTENDING** MED. DIRECTOR M.D. PHYS directar, page should be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) 23g. BURIAL CREMATION. REMOVAL (Specify) Providence Cemetery Carroll Co. DEC 19 196 24. FUNERAL DIRECTOR ADDRESS 2Sb. REGISTRAR'S SIGNATURE 1966 Waltz Box 241 Sykesville, Md.

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March 1			
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16998 CERTIFICATE OF DEATH death. requires that the death certificate be executed within 24 haurs after death and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission physician and campletely filled in by the funeral en please remave carbon papers. Pages 1 and o. COUNTY o. STATE b. COUNTY ARROLL MARY land MARYLAND b. CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (Is autside carporote limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 write RURAL and give nearest town) ALTI MORE MESVILLE 6 41. 6 mo. 500 p d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street/pddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? HUdso ar remaval, and in any event, within YES NO X NAME OF Last 4. DATE First Doy Year DECEASED OF DEATH (Type or print) 1966 NNA 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** 8. DATE OF BIRTH lost birthday) Months Days Hours TEMALE WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 10g. USUAL OCCUPATION (Give kind of work done during most of warking life, even if retired) COUNTRY? INDUSTRY 10ME 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME JAWARSKI 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO Address (Yes, no, or unknown) (If yes give war ar dates af service) signed by the atter burial-transit permi burial, crematian, a 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: RCULATORY COLLAPS IMMEDIATE CAUSE (a) physician. DUE TO Conditions, if ony, which gave THEROSCLEROSIS rise to immediate couse (a), DUE TO the haspital ar attending stating the underlying couse O FUNERAL DIRECTOR: After this certificate has been detached far use as the te Dept. af Health priar ta 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO X 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or tawn) (County) (State) Hour o.m. factory, street, office bldg., etc.) Nat While be de State at wark be retained by 21. I certify that (I) (this haspital) attended the deceased from 6 - 30, 1966, ta 12-35, 1966, that (I) (we) last saw the deceased alive on 12-25 1966, and that death occurred of 96 M, fram couses and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED M.D. PHYS DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S State directar, pa shauld be f NAME (Type) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (State) 23o. BURIAL, CREMATION, (County) Burial (Specify) 12/29/66 Sacred Heart of Mary Baltimore Co., Maryland 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR ADDRESS 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Brozdzinski Funeral Mome 1407 Eastern Ave. #21 DATE

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16999 CERTIFICATE OF DEATH certificate be executed within 24 haurs after death. death and campletely filled in by the funeral remave carbon papers. Pages 1 and PLACE OF DEATH USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City d. Carroll Co. MARYLAND b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn)

Sykesville c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If gutside carparate limits, write RURAL and give negrest town) six years Baltimore City d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital 5866 Belair Road YES NO TO 3 NAME OF 4. DATE First Last Month Day Year DECEASED Clinton 12 James 1966 (Type or print) Parks DEATH IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED X last birthday) Months Haurs white WIDOWED DIVORCED 2-1/1-01 male 10a. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, ar foreign country) 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR please during mast of warking life, even if retired) COUNTRY? Gas Station Maryland Laborer 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Asa Parks Geneva White IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. requires that the death (Yes, na, ar unknawn) (If yes give war ar dates of service) Springfield Hospital Records 215-14-3233 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: signed by the burial-transit p ONSET AND DEATH IMMEDIATE CAUSE (a) DUF TO Conditions, if ony, which gave (b) rise to immediate cause (a), **DUE TO** stating the underlying couse O FUNERAL DIRECTOR: After this certificate has been as the 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) far use treur selevotes NO the haspital ar 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I ar Part II af item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (County) (State) 20c. TIME OF INJURY Month, Day, Year factary, street, office bldg., etc.) Not While at wark at wark TO HOSPITAL OR ATTENDINA Page 4 may be retained by _, 19___, that (I) (we) last 21. I certify that (1) (this haspital) attended the deceased fram. . 19 , ta and that death accurred at_ M. fram causes and an the date stated above. saw the deceased alive an_ 19 22a. SIGNATURE 22b. DATE SIGNED ATTENDING MED. DIRECTOR STAFF PHYS. 12/24/66. M.D. PHYS director, page should be filed 22c. PHYSICIAN'S 22d. ADDRESS Springfield State Hospital NAME (Type) 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, (County) (State) REMOVAL (Specify) Gardens of Faith Cem. 12/27/66. Baltimore, Md. 2Sh. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 2Sa. REC'D BY REGISTRAR **ADDRESS** Leonard J. Ruck, Inc. Balto. Md. 21214 VR A15 (4) 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH eoth, PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) physicion ond campletely filled in by the funeral en pleose remove carbon papers. Pages 1 gad a. COUNTY o. STATE b. COUNTY MARYLAND c. LENGTH OF STAY IN 1b . CITY OR TOWN (If autside corporate limits, c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) yrite RURAL and give negrest tawn) stminster e. IS RESIDENCE ON A FARM? OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS nerA YES NO T enera 3. NAME OF Middle DATE Month Wit Day Year DECEASED 12 Dec 1966 DEATH (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX DATE OF 9. AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthdoy) Manths X DIVORCED WIDOWED 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT and in 10a. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? during mest of working life, even if retired) INDUSTRY FATMING FARMER 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME 1S. WAS DECEASED EVER IN U.S. ARMED FORCES 17. INFORMANT 16. SOCIAL SECURITY NO. Address (Yes, no, or,unknown) ((If yes give war ar dates of service) cremotia INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO burial, Canditians, if ony, which gove rise to immediate cause (a), DUE TO stating the underlying couse O FUNERAL DIRECTOR: After this certificate has been os the Heolth prior to 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) USe NO YES far 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 1B.) 20a. ACCIDENT WAS UNDERLYING the hospital OR CONTRIBUTING CAUSE OF DEATH of should be detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, farm, 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED (City or town) (County) (State) Haur o.m. factory, street, affice bldg., etc.) Nat While at work at work be retoined by 21. I certify that (1) (this hospital) attended the deceased from 121 1966. ta 1966, that (1) (we) last 1966, and that death occurred at 250 M, from causes and on the date stated above. saw the deceased alive on 22b. DATE SIGNED 22g. SIGNATURE M.D. DIRECTOR PHYS. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) directar, shouldb 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMAJORY (County) (Stote) 23a. BURIAL, CREMATION Sykes 2Sq. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR **ADDRES** VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH and 2 death hours after death, 1. PLACE DF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. CDUNTY by the Pages 1 a COUNTY b. CITY DR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY DR FOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND c. LENGTH DE STAY IN 1b ve carbon papers. Pag event, within 72 hours SYKesville BAIT : more = d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) filled d. STREET ADDRESS e. IS RESIDENCE DN A FARM? SPRING Field FRANCI NO X YES etely 3. NAME OF Middle DATE Month DECEASED (Type or print) Pivckney DEATH 1966 Elsie Flizabeth 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED last birthday) Months I 2-8-WIDDWED X DIVDRCED [Temale NEGro 1Da. USUAL OCCUPATION (Give kind of work done | 10b, KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) COUNTRY? ZLIS.A 13. FATHER'S NAME Eligah 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) | (If yes give war or dates of service) been signed by the burial transit permit in to burial, cremation, o 220-30-5590A Records - SpR: NG 7: eld StAT CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c),] ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). Bronchopneumonia attending physician. days DUE TO Arteriosclerotic Heart Disease Cenditions, If any, which Veers gave rise to immediate DUE TO (a), stating the underlying cause last. as PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Chronic brain syndrome associated with senile brain disease with WAS AUTOPSY PERFORMED? YES NO [Daychotic reaction Do Accident was underlying Dor Contributing Cause of Death (IF EITHER, NOTIFY MEDICAL EXAMINER) this cerum detached fo 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Day, Year 20f. (City or town) (State) (County) Hour a.m. While at work Not While at work P 21. I certify that (I) (this hospital) attended the deceased from 10 - 38 1966 to 12 - 7 1966, that (I) (we) last age 3 should iled with the 1966, and that death occurred at 11 P. M. from the causes and on the date stated above. saw the deceased alive on 12 - 7 22b. DATE SIGNED 22a. SIGNATURE 12/8/66 ATTENDING MED.
DIRECTOR FUNERAL 22c. PHYSICIAN'S 22d. ADDRESS director, p NAME (Type) Springfield State Hospital, Sykesville Rita S. Glahn 23d. LOCATION (City, town or county) 23b. DATE THEREDF 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, 2 12-12-66 Baltimore, Maryland Arbutus Memorial Park 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS Cuarley Charles R. Law 802 Madison Ave., Balto. Md. VR A15 (4) 20M 1/65

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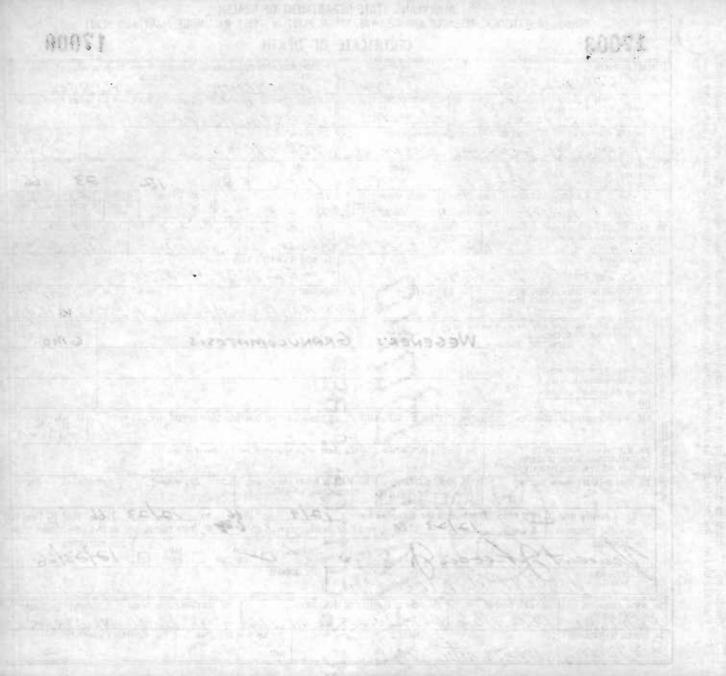
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MARYLAND STATE DEPARTMENT OF HEALTH

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	aftendi aftendi permit.			MRS WM. S. COONEY JR.	WESTMINSTERMA
	t the the sit p		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
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	R: A		saw the deceased alive on 12/23 1966	, and that death accurred at 6 M, fram cau	uses and an the date stated abave
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17004 CERTIFICATE OF DEATH 24 hours after death physicion and completely filled in by the funeral en please, remove corban popers. Pages I and 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY Carroll o. STATE Maryland Baltimore City MARYLAND ve corban popers. Pages 1 event, within 72 hours after b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn)

Sykesville c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Baltimore days d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) 2010 Maryland Ave. Springfield State Hospital YES NO to requires that the death certificate be executed within 3. NAME OF Middle First Last 4. DATE Month please remove corban and nony event, wit Doy Year DECEASED HARVARD WALLACE RONEY 19 66 DECEMBER (Type or print) DEATH S. SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. NEVER MARRIED 7. MARRIED last birthday) Months Days Haurs /White 7-14-02 DIVORCED M WIDOWED Male 10a. USUAL OCCUPATION (Give kind af wark dane 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Caunty & State, or fareign country) 12. CITIZEN OF WHAT COUNTRY? during mast of working life, even if retired) INDUSTRY Pennsylvania Plasterer 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME cremotion, or remova Edward Roney Mary Deary signed by the attending burial-transit permit. The 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor ar dates af service) 17. INFORMANT 16. SOCIAL SECURITY NO. Address 153-01-0843 Unk. Records, Springfield State Hospital INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Far advanced, bilateral cavitary pulmonary ears attending physician. tuberculosis DUE TO Canditions, if any, which gave (b) rise to immediate couse (a). DUE TO stating the underlying cause has been use os the last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)

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MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21801. 17005 CERTIFICATE OF DEATH death. The law requires that the death certificate be executed within 24 haurs after death physician and campletely filled in by the funeral en please remave carban papers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY arral a STATE b. COUNTY MARYLAND c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest town) write RURAL and give negrest tawn) within 72 haurs IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR/INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS YES NO D NAME OF Middle DATE Month Day Year DECEASED event, (Type or print) DEATH 19 IF UNDER 1 YEAR IF UNDER 24 HR 6. COLOR OR RACE 9. AGE (In years 7. MARRIED NEVER MARRIED DATE OF BIRTH last birthday) Manths Days Hours and in pmy WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? Cal 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remaval, 50 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SICURITY NO. 17. INFORMANT Address (Yes, na, ar unknown) (If yes give war ar dates af service) crematian, 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17006 CERTIFICATE OF DEATH death. and completely filled in by the funeral remove carbon papers. Pages than PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY b. COUNTY MARYLAND CITY OR TOWN (If outside corporate limits CLENGTH OF STAY IN 15 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) write RURAL and give nearest town d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS within YES NO DO 3. NAME OF 4 DATE First Middle Last Month Dov Year DECEASED OF DEATH 12 1966 (Type or print) S. SEX 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. NEVER MARRIED last birthday) Months Days Hours WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY 2 USEKE 13. FATHER'S NAME MOTHER'S MAIDEN 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, na, or unknown) (If yes give war, or dates of service) INTERVAL BETWEEN ONSET AND DEATH 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) buriol-tronsit PART I, DEATH WAS CAUSED BY: CONGESTIVE IMMEDIATE CAUSE (o) DUF TO Canditions, if any, which gave HRTERIO SCLEROTIC rise ta immediate cause (a). DUF TO stating the underlying cause TO FUNERAL DIRECTOR: After this certificate has been os the last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) for use NEUMONITIS BILATERAL YES NO the hospital or 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) detoched (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or tawn) (County) (Stote) 20c. TIME OF INJURY Manth, Day, Year Haur o.m. foctory, street, office bldg., etc.) Not While be retoined by 1966 to 21. I certify that (1) (this haspital) attended the deceased fram... 11/30 12/1 , 1966, that (1) (we) last 19 66, and that death accurred at 10 37 M, fram causes and an the date stated above. saw the deceased alive an_ 12/1 220. SIGNATURE 225. DATE SIGNED **ATTENDING** MED. DIRECTOR M.D. PHYS. director, page should be filed 22d. ADDRESS PHYSICIAN'S NAME (Type) WESTMINSTE 23a. BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote)

2Sa. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

1966

VR A15 (4) 20 M 1/66

REMOVAL (Specify) 24. FUNERAL DIRECTOR

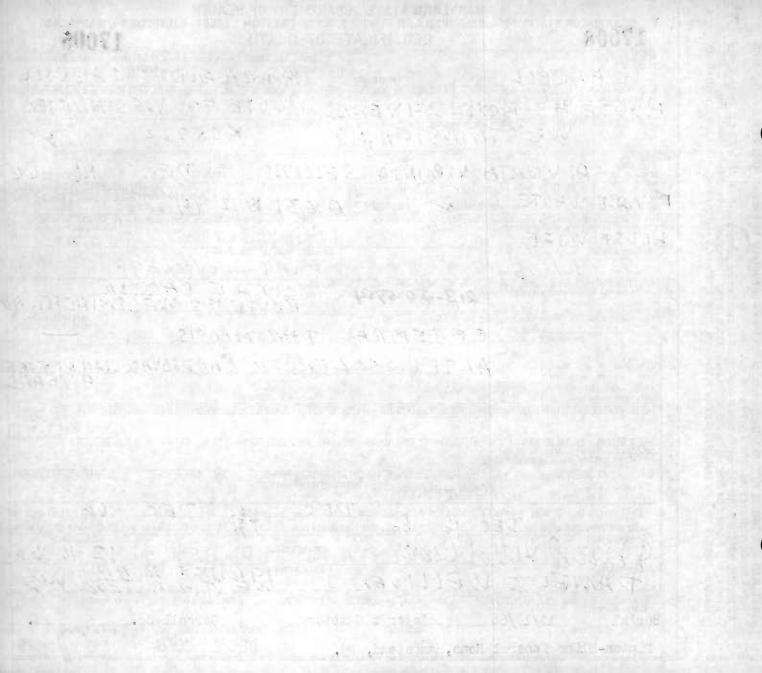
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17007 CERTIFICATE OF DEATH the ottending physician and campletely filled in by the funeral sit permit. Then please remave carban papers. Pages 1 and 2 requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH a. COUNTY a. STATE b. COUNTY Carroll Maryland MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural -- Sykesville Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) e. IS RESIDENCE ON A FARM? 12 d. STREET ADDRESS Springfield State Hospital 2600 Ailsa Avenue YES NO DE Middle 4. DATE First Lost Day Year DECEASED OF DEATH 12 19 66 Ella 20 Catherine Russell (Type or print) IF UNDER 1 YEAR | IF UNDER 24 HRS. SEX 8. DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED birthdoy) Months Doys Hours 3/20/83 X female white WIDOWED DIVORCED 11. BIRTHPLACE (County & Stote, or fareign country) 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT COUNTRY? during most of warking life, even if retired) **INDUSTRY** Maryland USA housewife 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Ella Duffy John Duffy IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT signed by the ottendin burial-tronsit permit. burial, crematian, ar re-(Yes, no, or unknown) (If yes give wor or dotes of service) Springfield Hospital records, Sykesville, Md. 215-16-2223 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH Cardiac failure days IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gave rise to immediate couse (a), DUE TO stating the underlying couse TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital ar attending TO FUNERAL DIRECTOR: After this certificate has been as the lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) far use Chronic brain syndrome associated with senile brain disease with NO X YES psychotic reaction 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Hame, farm, (City or town) (State) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED (County) Haur a.m. foctory, street, affice bldg., etc.) Not While 19 ot work ot wark 7/15/ . 19 66 . ta 12/20/... 19.66, that the (we) last 2]. I certify that P\$ (this haspital) attended the deceased fram. 1966, and that death occurred ap: 00a M, from causes and an the date stated above 2/20/ saw the deceased alive an. 220. SIGNATURE 22b. DATE SIGNED ATTENDING 12/20/66 M.D. DIRECTOR PHYS. PHYS. Springfield State Hospital 22c. PHYSICIAN'S 22d. ADDRESS NAME(Type) Naci N. Buyukunsal, M.D. Sykesville. Maryland director, shauld b 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) 23a. BURIAL CREMATION. REMOVAL (Specify) 12/23/66. Woodlawn Cemeterv Baltimore, Md. 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE **ADDRESS** 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Leonard J. Ruck, Inc. Balto. Md. 21214 Ochorelas DEC 9

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O HOSPITAL OR ATTENDING	Page 4 may be retained by to reven the street of the stree	MED	21. I certify that (I) (this hospital) attended the deceased from PEC, 1962, to PEC, 1966 that (I) (we) last saw the deceased alive on PEC, 16, and that death occurred at \$750 M, from the causes and on the date stated above. 226. PHYSICIAN'S 226. PHYSICIAN'S 226. ADDRESS PLOSE NO. PHYS. 227. ADDRESS PLOSE NO. PHYS. 227. ADDRESS PLOSE NO. PHYS. 227. ADDRESS PLOSE NO. PHYS. 228. ADDRESS PLOS
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		02	24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before edmission) a. COUNTY b. COUNTY Carroll by the and 2 death. MARYLAND Carroll b. CITY OR TOWN (if outside corporete limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give neerest town) c. LENGTH OF STAY IN 16 write RURAL end give neerest town)
Middleburg mo. Rural--Westminster d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress) e. IS RESIDENCE d. STREET ADDRESS ON A FARM? Brookfield Manor Nursing Home R.D. YES NO D 3. NAME OF Middle 4. DATE Month Day Yeer DECEASED (Type or print) SHIPLEY DEATH URNER 1966 Dec. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH IF UNDER 24 HRS. 9. AGE (In years | IF UNDER 1 YEAR and last birthday) Months WIDOWED DIVORCED X May male The law requires that the death certificate 10a. USUAL OCCUPATION (Give kind of work 1Db. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? 11. BIRTHPLACE (County & State, or foreign country) done during most of working life, even if retired) farmer U.S.A. retired Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Shipley Annie Zepp Grove 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (Ifyes give wer or dates of service) Westminster, Md. Ralph G. Hoffman. no none 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] attending physician. ONSET AND DEATH 10 Vescular accident PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO Conditions, if eny, which (b) gave rise to immediate cause DUE TO (e), steting the underlying ceuse lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISPASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO (an dio 1) ascur V que ase 20e. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Pert II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached 20d. INJURY OCCURRED I 20e. PLACE OF INJURY (Home, farm, ! 20f. (City or town) (County) (Stete) 20c. TIME OF INJURY Month, Dey, Yeer factory, street, office bldg., etc.) While Not While Hour e.m. at work et work Should be de p.m. 21. I certify that (I) (this hospital) attended the deceased from 51.19 to...(2 ..(ef., 19, that (1) (we) last CP. 19......, and that death occurred at 7.2.M, from the causes and on the date stated above. saw the deceased alive on J DATE 228. SIGNATURE ATTENDING 1 PHYS. DIRECTOR PHYS. M.D. HOSPITAL death. Page 4 O FUNERAL with th 22d. ADDRESS 22c. PHYSKIAN'S NAME (Type) Union Bridge, Md. director, 1 236. BURIAL, CREMATION, | 236. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) REMOVAL (Specify) OH Co. Maryland Deer Park 7-1966 Carroll 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) C.M. Waltz, Box 241, Sykesville, Md. Musiles & 1SM 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH DUVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH and 2 death. and PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY Pages 1 urs after after the MARYLAND b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) hours à write RURAL and give nearest town) 24 hours = papers. filled d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE event, within 72 ON A FARM? 13 NO P YES completely f executed within NAME OF First Middle DATE Month Day Year DECEASED DF (Type or print) DEATH 1966 6. COLOR DATE OF BIRTH OR NEVER MARRIED AGE (In years | IFUNDER 1 YEAR | IFUNDER 24 HRS. remove 7. MARRIED Months 1 Davs Hours any and WIDOWED DIVORCED physician n please r = 10a. USUAL OCCUPATION (Give kind of work done) 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? and death certificate FATHER'S NAME MOTHER'S MAIDEN NAME removal ed by the attending paramit. Then, cremation, or remova 77/ COTO 15. WAS DECEASED EVER IN D.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT Address 17. (Yes, no, or unkown) (If yes give war or dates of service) 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c) INTERVAL BETWEEN PHYSICIAN: The law requires that the ONSET AND DEATH PART I. DEATH WAS CAUSED BY: attending physician. IMMEDIATE CAUSE (a signed been signer the burial-t DUE TO Conditions, If any, which (b) gave rise to Immediate DUE TO cause (a), stating the as th underlying cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS for use Health PERFORMED? certificate CERTIFICAT YES NO Com this certetation 20a. ACCIDENT WAS UNDERLYING T DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING TI CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm.) 20f. (Clty or town) (County) (State) factory, street, office bldg., etc.) be de State Hour a.m. While Not While After OR ATTENDING be retained by at work at work ould the 21. I certify that (1) (this hospital) attended the deceased from 1966 that (I) (we) last DIRECTOR: age 3 should lied with the saw the deceased alive on and that death occurred at 12 M, from the causes and on the date stated above. DATE SIGNE 22a. SIGNATURE 22b. ATTENDING page STAFF M.D. PHYS. DIRECTOR PHYS там Page 4 may 0 FUNERAL TO HOSPITAL TO FUNERAL director, pa 22c. PHYSICIAN'S 22d. **ADDRESS** NAME (Type) BURIAL, CREMATION. 23h DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) Rurri a 7 Manchester Cemeter anche ster REGISTRAR'S SIGNATURE FUNERAL DIRECTOR REC'D BY REGISTRAR Tipton-Eline Fun. Home, Hampstead, Md. DATE DEC VR A.15 (4) 20M 1/65

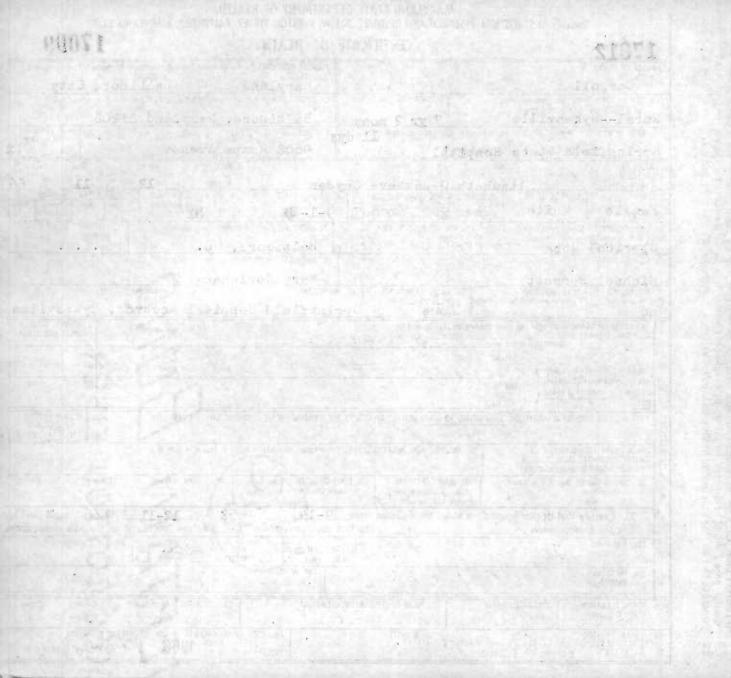
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CONTRACTOR OF THE PROPERTY OF MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CEPTIFICATE OF DEATH

	17012			CERTI	FICATE	OF DEATH				T	103	
1.	PLACE OF DEATH			MENT HOUSE		2. USUAL RESIDENCE (Where dec	eased lived, if institu	tion: Reside	ence befor	e odmissio	9n)
	a. COUNTY Carro	11		MAR	RYLAND	o. STATE Marylan	d	Bal	INTY timor	e 6	tv	
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	d. NAME OF HOSPITA	AL OR INSTITUTION (If no	ot in hospital, g	give street address)	11 dv	d. STREET ADDRESS	5740	Cedonia	Ave		e. IS RESID	DENCE
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3.	NAME OF	Fi	rst	Middle		Last	4. DAT	E Mar	nth	Day	Yeo	ar
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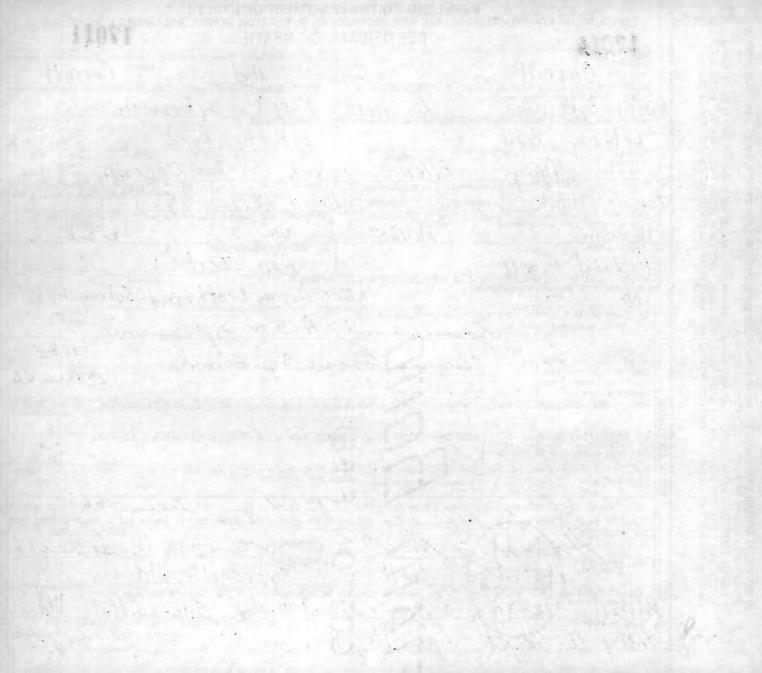
TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physician and completely filled in by the funeral adirector, page 3 should be detoched for use as the buriol-transit permit. Then please remove corbon papers. Pages 1 and 2 should be filled with the Stote Dept. of Health prior to burial, cremotion, or removal, ordain any event, within 72 hours after death... **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the deoth certificote be executed within 24 haurs after deoth. Page 4 may be retained by the hospital or ottending physicion. VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 17013 requires that the death certificate be executed within 24 hours after death. sician and completely filled in by the funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE Carroll MARYLAND Maryland b. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn)
Westminster c. CITY OR TOWN (If autside carporote limits, write RURAL and give neorest town) CLENGTH OF STAY IN 16 Rural -- Sykesville hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? within 72 Co.General Hospital Liberty Road YES NO TX NAME OF First Middle 4. DATE Month Last Doy Year DECEASED 19 66 KATHERINE H. STEM Dec. (Type or print) DEATH S. SEX 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 8. DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthday) Months Hours Days female white WIDOWED DIVORCED rch a. 1916 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during mast of working life, even if retired) **INDUSTRY** COUNTRYA Maryland Sec v Insurance 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME G. Millard Holter Bessie Kefauver 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, qo, or unknown) (If yes give war ar dates of service) 214-18-9472 W.F. Stem same as INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY: signed by the burial-tronsit p ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Canditians, if ony, which gove rise to immediate cause (a). DUE TO stating the underlying cause the hospital or offending as the TO FUNERAL DIRECTOR: After this certificate hos been 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for use YES A NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, office bldg., etc.) Nat While at work ot work be retoined by 21. I certify that (1) (this haspital) attended the deceased fram Dec 3, Dec 3 196, that (1) (we) last 1966 ta 1966, and that death occurred of 45 saw the deceosed alive on_ _M, from causes and an the date stated obove. 220. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. PHYS. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) M. D. 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Ebenezer Carroll Co. Marvlanfo ADDRESS 25g. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Charles VR A15 (4) 1966 DATE DEC C.M. Waltz, Box 241, Sykesville, Md.

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PHYSICIAN: The law requires that the hospital or attending physician, this certificate has been signed by detached for use as the burial-trane Dept. of Health prior to burial, cre	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.) 19. WAS AUTOPSY PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.)
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ATT reta ccto sho vith	saw the deceased alive on 18 1966, and that death occurred at 20M, from the causes and on the date stated above.
y be DIRE age 3	Howard & Hall M.O. ATTENDING DIRECTOR D
TO HOSPITAL OR ATTEN Page 4 may be retain TO FUNERAL DIRECTOR. director, page 3 shou should be filed with th	22c. PHYSICIAN'S NAME (Type) HOWARD E. HALL 22d. ADDRESS SY KESVILLE, Md.
Page Page FUI direc	23a BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county)
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VR A15 (4)	Harry W. Haight Sykasville, M. DATE JAN 4 1967 golianles Judge
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 17015 law requires that the deoth certificate be executed within 24 hours after deoth. physician and completely filled in by the funeral serve please remove corbon papers. Pages 1 and 2 oval and in ony event, within 72 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY Carroll a. STATE b. COUNTY MARYLAND Maryland Carroll b. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newborn Westminster Westminster d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? Carroll County General Hospital 820 Baltimore Blvd YES NO Y 3. NAME OF First 4. DATE Manth Day Year DECEASED Baby Boy (Type or print) Turfle 19 66 DEATH S. SEX IF UNDER 1 YEAR 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years last birthday) IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED Months Davs Hours WIDOWED DIVORCED ecember 9. Male White 1966 20 10a. USUAL OCCUPATION (Give kind af work done 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, ar fareign cauntry) 12. CITIZEN OF WHAT during mast af warking life, even if retired) INDUSTRY COUNTRY? Not applicable

13. FATHER'S NAME Not applicable Carroll County, MD United States 14 MOTHER'S MAIDEN NAME the attending phys James W. Turfle Nannie M. Hill IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT 820 Baltimore Blvd. (Yes, no, or unknown) (If yes give wor ar dates of service) No None Westminster, Maryland 21157 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) INTERVAL BETWEEN signed by the buriol-tronsit p PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO 20 m Canditians, if any, which gave rise ta immediate cause (a). DUE TO stoting the underlying cause be retained by the hospitol or attending this certificate hos been detached for use os the last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? YES X NO 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20c. TIME OF INJURY Month, Doy, Yeor (City ar tawn) (Caunty) (State) Hour o.m. foctory, street, affice blda., etc.) Not While at wark ATTENDING O FUNERAL DIRECTOR: After at wark 21. I certify that (1) this haspital) attended the deceased fram 12/9 . 19 66, that (1) (we) last . 1966 ta 19 66, and that death accurred at 6:04 M, fram causes and an the date stated above. saw the deceased alive an 22a. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. DIRECTOR PHYS 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) William R. O'Rourke, M.D. 150 W. Main St., Westminster, MD director, 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a. BURIAL CREMATION. 23b. DATE THEREOF (County) (State) Released to 25o. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE h & STORE ATTECTOR **ADDRESS** VR A15 (4 1966 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17016 CERTIFICATE OF DEATH death The law requires that the death certificate be executed within 24 hours after death and campletely filled in by the funeral remove carban papers. Pages 1 and 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY a. STATE b COUNTY Carroll MARYLAND Maryland Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If autside carparete limits. c. LENGTH OF STAY IN 16 write RURAL and give nearest town)
Rural-- Sykesville remove carban papers. Pac n any event, within 72 haurs Cumberland 2m 1d d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 1507 Frederick Street Springfield State Hospital YES NO 3 3. NAME OF Middle 4. DATE Year Day DECEASED ANNA MAE TWIGG (Type or print) 1966 DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 7. MARRIED NEVER MARRIED 73-73 vrs. Manths Days Hours 7-26-93 WIDOWED DIVORCED Female White 10a. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR during mast af warking life, even if retired) fe Own Home COUNTRY? U.S.A. none Cumberland, Md 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Mary Connors Isaac Norris 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, na, ar unknawn) ((If yes give war ar dates af service) 17. INFORMANT 16. SOCIAL SECURITY NO Address 220-54-6027 Springfield Records, Sykesville, Md. crematian. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-transit p burial, crematic ONSET AND DEATH Heart Failure (days) IMMEDIATE CAUSE (a). be retained by the haspital ar attending physician. DUF TO Arteriosclerotic heart disease (years) Canditians, if any, which gave Page 4 may be retained by the haspital or with Page 4 may be retained by the haspital or with the serificate has been significant, page 3 shauld be defached far use as the burdent page 3 shauld be defached far use 3 shauld be defached far us rise to immediate cause (a), DUF TO stating the underlying cause PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? .B.S. with cerebral arteriosclerosis with behavioral reaction YES X NO F 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Port II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (City or town) (County) (State) Not While factory, street, affice blda., etc.) at wark at wark 21. I certify that (d) (this haspital) attended the deceased fram 10-11, 19-62, ta 12-12, 19-66, that (3) (we) last saw the deceased glive an 12-12 1966, and that death accurred at 11:0 Mp from causes and an the date stated above. , 1966, that (% (we) last saw the deceased alive an 12-12 22a. SIGNATURE 22b. DATE SIGNED 12-13-66 M.D. DIRECTOR 22d ADDRESS 22c. PHYSICIAN'S Springfield Hospital, Sykesville, Md. NAME (Type) Ilse Kamm, M.D. 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) 23a. BURIAL, CREMATION, Burial (Specify) Greenmount Cemetery Cumberland, Md. Allegany Dec.16.1966 250. REC'D BY REGISTRAR 198636. REDISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 James F. Scarpelli, Cumberland, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17017 CERTIFICATE OF DEATH be executed within 24 hours ofter deoth 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY
Carroll a. STATE b. COUNTY fease remove corbon papers. Pages 1 and in ony event, within 72 hours after MARYLAND Maryland Montgomery
c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) in by the Pages b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b Sykesville lvr.6mos.10dvs. Bethesda IS RESIDENCE ON A FARM? d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) filled NO To 8616 Irvington Avenue YES Springfield State Hospital NAME OF Middle DATE Year DECEASED (Type or print) LEWIS CALWELL WEST 1966 December DEATH 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthday) Months Hours Male 7-20-75 White WIDOWED X DIVORCED 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if refired)
Farmer **INDUSTRY** COUNTRY? requires that the deoth certificate Virginia U.S.A 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, cremation, or removal, Lewis West Belle Fauntleroy 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, na or unknawn) (If yes give war ar dates af service) permit. 220-54-6265 Records, Springfield State Hospital INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) signed by the buriol-tronsit p PART I. DEATH WAS CAUSED BY QNSET AND DEATH IMMEDIATE CAUSE (a) Bilateral bronchopneumonia davs Poge 4 moy be retained by the hospital or attending physician. DUE TO Conditions, if ony, which gave rise to immediate cause (a), DUE TO stating the underlying cause os the hos been (d) Arteriosclerotic heart disease years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction. 19. WAS AUTOPSY PERFORMED? for use Heolth YES X NO FUNERAL DIRECTOR: After this certificate 20g. ACCIDENT WAS LINDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH of (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) 20d INJURY OCCURRED 20c. TIME OF INJURY Manth, Day, Year Hour o.m. factory, street, affice bldg., etc.) Not While at work at wark ta 12-1-66, 19 , that (1) (we) last 21. I certify that (!) (this haspital) attended the deceased from_ 3 should saw the deceased alive an 12-1-66 19 , and that death accurred at 1:20 NP, 180m causes and an the date stated above 22b. DATE SIGNED 22a. SIGNATURE MED. DIRECTOR **ATTENDING** 12-1-66 M.D. PHYS. director, poge 3 filed 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz. M.D Sykesville, Maryland 2178h 23b. DATE THEREOF 23ca NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) BURIAL, CREMATION, 230. REMOVAL (Specify) Asonic 66 TSAINGTON 2Sb./REGISTRAR'S SIGNATURE 2Sq. REC'D BY REGISTRAR FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 1966

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17018 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death death pup and campletely filled in by the funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY b. COUNTY Baltimore Maryland Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Westminster c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) CLENGTH OF STAY IN 1b 16 days Balto. 21212 Idlewvlde d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Carroll County General Hospital 6514 Banbury Road YES NO 2 NAME OF First Middle Lost 4. DATE Month Dov Year DECEASED 1966 White. Jr. December 20. Charles Steuart (Type or print) DEATH 9. AGE (In years last birthdoy) IF UNDER 1 YEAR S. SEX 6. COLOR OR RACE IF UNDER 24 HRS. 7. MARRIED TO 8. DATE OF BIRTH NEVER MARRIED Months Doys Hours WIDOWED DIVORCED □ August 14.1908 Male White 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT please during most of working life, even if retired) **INDUSTRY** COUNTRY ? Maryland Own Auto Dealer Agency 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Blanche Macey Charles S. White. Sr. 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) Family Records CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
 PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-transit ONSET AND DEATH IMMEDIATE CAUSE (o) DUF TO Coronary Thrombosis Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse Page 4 may be retained by the haspital ar attending TO FUNERAL DIRECTOR: After this certificate has been as the 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) far use NO YES 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or town) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED (County) (Stote) foctory, street, office bldg., etc.) Not While of work ot work 21. I certify that (1) (this haspital) attended the deceased fram Dec 4, 1966, ta De 20, 1966, that (1) (we) last saw the deceased alive an Dec 20, 1966, and that death accurred at 25 M, fram causes and an the date stated abave. 1966 to Dec 20, 1966 that (1) (we) last 22b. DATE SIGNED 22o. SIGNATURE **ATTENDING** M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) (westmenste director, I shauld be 23o. BURIAL, CREMATION, REMOVAL (Specify) 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) Parkville. Maryland Moreland Memorial 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66 John Burns' Sons, Towson, Maryland

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low re Page 4 may be retained by the hospital or attending TO FUNERAL DIRECTOR: After this certificate has been director, page 3 should be defached for use as the should be filed with the State Dept. of Health prior to		sow the deceased glive on 12 6	A.D. M.D.	death accurred at 11. ATTENDING ME DIS	M, from causes and a	n the date stated above DATE SIGNED 2.7 6 6
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